ABSTRACT

A qualitative feminist study, informed by social constructionist epistemology, antiracist theories and intersectionality perspectives, was conducted in order to understand South Asian immigrant women’s access to and experiences with breast and cervical cancer screening services in Canada. Particular attention was paid to the wider context of their lives and their experiences of migration, resettlement, integration and general access to the Canadian healthcare system. The study also explored how the broader systems, structures and policies in Canadian society shape South Asian immigrant women’s participation in and access to cancer screening services. Thirty-one South Asian immigrant women were interviewed in individual, couple and group settings in greater Vancouver. Research findings indicated that women’s age, length of stay since immigration, educational and generational status, not/having a family history or symptoms impact their use or lack of use of cancer screening services; but these factors also intersect in complex ways with various systemic and structural issues including not/having a recommendation from physicians, women’s financial in/stability, access to income, employment, settlement services and community resources, levels of socioeconomic integration and familiarity with the Canadian healthcare system, and gender roles and responsibilities. Women’s narratives also showed that the immigration factor amplify the intersecting forms of inequities and the social determinants of health such as gender, class, poverty, racialization and discrimination, and affect women’s physical and mental health and access to healthcare services, cancer screening being one of them. An intersectional analysis revealed that the gendered and racialized immigration and integration policies, multicultural discourses and neoliberal ideologies and practices intersect to situate South Asian immigrant women into racialized and disadvantaged situations as the ‘other’ wherein access to preventive cancer screening services becomes especially challenging. South Asian women’s access to cancer screening and other healthcare services needs to be understood beyond the attempts to know their cultural health beliefs and practices, and beyond the neoliberal ideas of ‘self-care,’ ‘individual responsibility,’ ‘patient empowerment,’ and ‘culturally sensitive care.’ Also, equitable access to health care cannot be ensured without resisting these women’s racialized position as the ‘other’ and addressing the social, political, historical, material and structural inequities in Canadian society.
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To my parents who have blessed me with immense love and support
CHAPTER 1: INTRODUCTION AND OVERVIEW

Setting the Research Context

Breast and cervical cancers are two major life-threatening illnesses for women in Canada as in anywhere in the world. Over the lifetime, approximately one in nine Canadian women will develop breast cancer and one in 28 Canadian women will die from it, the second leading cause of mortality among women after lung cancer (Canadian Cancer Society 2009). While cervical cancer is the tenth most common cancer among Canadian women of all ages, it is the third most common among women aged 20 to 49 (ibid.). Mammogram and Pap smear screening are considered the best currently available methods of secondary prevention through early detection and reduction of mortality of breast and cervical cancers respectively. Mammograms are x-rays of the breasts and a screening mammogram looks for an unsuspected, hidden cancer in women who are healthy and who have never had breast cancer (BC Cancer Agency). The Papanicolaou (Pap) smear test is used to detect changes to cervical cells, and women are recommended to have regular Pap tests in order to detect cell changes while treatment can be effective or before they become cancerous. The BC Cancer Agency's Cervical Cancer Screening Program (CCSP) has succeeded in reducing cervical cancer incidence rates by over 70 percent (ibid.).

However, a substantial number of studies on cancer screening behaviour among women in Canada reveal that immigrant women, women with lower socioeconomic status, Aboriginal women and South Asian women in particular, are less likely to participate in mammogram and Pap smear services as compared to Caucasian and non-immigrant women (Ahmad and Stewart 2004; Bottorff et al. 2001; Bryant, Browne, Barton and Zumbo 2002; Chan 2002; Choudhry, Srivastava and Fitch 1998; Gupta, Kumar and Stewart 2002; Grewal, Bottorff and Balneaves 2004; Hislop, Mumick and Yelland 1995; Hislop, Bajdik, Regier and Barroetavena 2007; Johnson et al. 1999; Ogilvie et al. 2004; Lofters, Moineddin, Hwang and Glazier 2011; Lofters, Moineddin, Hwang and Glazier 2010; Woltman and Newbold 2007). While the underutilization of reproductive cancer screening among South Asian immigrant women is a well known fact, little is known about the ways in which their lack of access to these services is affected by the broader systems, structures and policies that shape the life circumstances of these women.
Defining South Asian Women

Statistics Canada (2008) reported that in both 2001 and 2006, India and Pakistan represented the second and fourth leading source county respectively of newcomers to Canada. Thus South Asians surpassed Chinese people as the largest ‘visible minority’ group in Canada in 2006. Although fully 14% of recent immigrants who arrived between 2001 and 2006 came from the People's Republic of China, India and Pakistan represented 11.6% and 5.2% of new immigrants correspondingly in 2006 (ibid.). According to the 2006 Census report, ‘visible minorities’ made up about a quarter (24.8%) of British Columbia’s total population, the highest among all provinces and territories in Canada (WelcomeBC 2008). The same source also showed that South Asians (26% of ‘visible minority’ population and 6.4% of the total population) constituted the second largest ‘visible minority’ group in the province. Apparently, the growth of ‘visible minority’ population is mainly attributed to high rates of immigration to Canada from non-European countries. In 2006, fully 75% of recent immigrants who arrived since 2001 were ‘visible minorities’ compared to 72.9% in 2001 and 74.1% in 1996 (Statistics Canada 2008).

The term ‘visible minority’ is defined in the federal Employment Equity Act as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour” (WelcomeBC 2008). Hence, this is a category labelled against the ‘non-visible’ or dominant white populations in Canada. Such processes of categorization reinforce white domination which is viewed as the standard, and also standardize people of diverse ethnic, linguistic, religious, educational, geographical and cultural backgrounds as the ‘other.’ Similarly, women from India, Pakistan, Bangladesh, Sri Lanka, and Nepal, and women with Indian origin coming from Fiji, East Africa, and the Caribbean are usually grouped together in the common discourse in Canada as South Asian women. A South Asian academic and social worker in Canada, Usha George (1992), made an interesting remark that the only characteristic these women share in common is that they come from tradition oriented patriarchal societies with strong extended family ties. This, however, tends to create stereotypes about South Asian women who are most often represented in mainstream health research and particularly in cancer screening research as the cultural ‘other’ and the ‘victim’ of their culture and tradition. Their otherness is maintained through the multiculturalist discourse of culture and community that tends to ascribe a static notion of subjectivity, geography and culture on ethnic minority people while ignoring the
gender, class and other power imbalances among South Asian people. Through the multicultural discourse “ethnic communities are imagined as pre-modern, tradition bound, and culturally backward” (Thobani 2007, 163). Dominant assumptions about ethnic minority communities as homogenous and bounded spaces tend to promote ghettoization of racialized immigrant women and hinder their integration into the broader Canadian society perpetuating their ‘otherness.’ The multiple and diverse realities and needs of South Asian communities are ignored through the homogenization and stereotypical representation of these communities. The current study attempted to resist such culturalization of ethnic minority communities and instead promote a critical understanding of community as a political category made up of complex and diverse power relations rather than as a fixed category, and as a source of both oppression and emancipation for South Asian women (Ponic 2007; Vissandjee, Apale and Wieringa 2009).

Popularly, culture is interpreted and essentialized as “values, beliefs, knowledge, and customs that exist in a timeless and unchangeable vacuum outside of patriarchy, racism, imperialism, and colonialism” (Razack 1994, 896); but critical antiracist and postcolonial feminists have resisted the oversimplified notions of culture and community as pre-given or natural constructs. They have rejected the essentialist conceptualization of ethnic communities as homogenous cultural groups and emphasized the internal variations within communities based on gender, class, age, ability, sexuality and other dimensions. Critical perspectives have contextualized health and healthcare practices of ethnic minority women within the broader political, economic, historical, and social contexts, and the existing structural inequalities of Canadian society. Similarly, in this study, I have problematized the notion of a distinctive or monolithic ‘South Asian culture’ that is predominantly used in literature as the explanation for the health inequities experienced by racialized immigrant women. I recognize culture as a dynamic way of living that is shaped and transformed by migration processes as well as by changing historical, social, economic and political relations. I also appreciate culture as an important health determinant that intersects with other social relations of power to influence people’s health practices and access to healthcare services.

The South Asian women in the current study were born in India, Pakistan, Bangladesh, Sri Lanka, Fiji and Canada, were predominantly first generation immigrant women who had migrated to Canada from these countries as well as from the UK and the USA, and were living in
the greater Vancouver area as either citizens or permanent residents. Only one self-identified South Asian immigrant woman was born in Canada. Broad categories, such as South Asian immigrant women apparently tend to lump together women of diverse classes, religions, languages, educational, employment or immigration statuses, ages and generations, while the experiences of these women with the Canadian health care and other systems are likely to vary according to their varied backgrounds. Nonetheless, such social and political identities provide certain standpoints or common grounds for antiracist solidarity, activism, and the struggle against domination (Agnew 1996; Mohanty 1991). In the current research I tried to conceptualize and represent South Asian immigrant women not as a homogenous cultural group but as “a sociopolitical designation … oppositional political relation to sexist, racist, and imperialist structures that constitutes … potential commonality” (Mohanty 1991, 7, emphasis original).

Outline of the Research Problem

Existing critical feminist and antiracist literature on South Asian immigrant women’s socioeconomic and health status reveals that several intersecting policies and structural factors situate these women into the position of the ‘other,’ wherein they are perceived as incompatible with the national (bilingual and bicultural) characteristics of white Canada (Anderson and Kirmham 1998; Bannerji 2000; Dossa 2005; Thobani 2001, 2007; Zaman 2006). It is from such a position that they try to access health care and other services. But research on South Asian immigrant women’s access to cancer screening services rarely takes into account the broader political, economic, historical, and social contexts within which these women access healthcare services. Most studies on these women’s use of cancer preventative health care maintain a focus on cultural barriers while viewing these women’s cultural understandings of health and illnesses such as breast and cervical cancer as the most important determinants of their under-participation in cancer screening. A number of studies have also examined these women’s cultural beliefs and knowledge about and attitudes towards breast and/or cervical cancer and screening processes. These studies recommend culturally sensitive service delivery by healthcare providers and increased awareness about these cancers and screening services among South Asian women. Culture is framed in such literature as the main problem or barrier to these women’s access to cancer screening services, rather than as one of the many contextual aspects that influence women’s lives and health. Such a culturalist approach not only views culture as pre-given, static,
and independent of the social, historical, economic and structural contexts, it also deflects attention from systemic racism and discriminatory practices of the health care and other institutions in Canada while attributing the problem of inequitable access to the culture of these women. This approach also constructs South Asian women as a homogenous group or as the ‘other’ while overlooking their internal differences and complex and diverse social locations. A dominant focus on the cultural barriers to health care results in a lack of consideration of how systemic and structural barriers in Canadian society (such as, racial discrimination and class inequities, poverty and social isolation faced by immigrant women) influence the accessibility of cancer screening and other health services. A lack of focus on the systemic and structural factors also tends to result in blaming individual women for their own poor health, or for failing to take responsibility for prevention of illnesses, or cancer in the present context. These problems were addressed in my research on South Asian immigrant women and cancer screening.

The existing literature has also failed to capture the unique gendered and racialized experiences of these women as immigrants, especially the dynamics of migration and relocation in their lives. Thus there was a particular need for further research in the area that is “sensitive to the experiences of migration above and beyond the recognition of cultural diversity” (Vissandjée, Thurston, Apale and Nahar 2007, 222). Only a few studies have examined how some of the systemic issues within the Canadian healthcare system influence South Asian women’s participation in cancer screening. Further research seemed to be still necessary to critically explore how the broader structures, policies, discourses and processes intersect to shape these women’s access to and experiences with cancer screening services.

Understanding health disparities, according to Weber and Parra-Medina’s insightful argument, requires that we examine the broader social, cultural, economic and political processes of social inequities that control or influence the nature and extent of these disparities. Critical feminist health researchers have used antiracist and postcolonial theories to examine the deeper and broader structural forces (such as gender discrimination, racial and class exploitation, colonization, poverty, globalization) that determine the health and the illness of marginalized people (Anderson 2000). Antiracist perspectives and especially the intersectionality paradigm explicate healthcare practices of racialized and marginalized people within larger interlocking political, economic, historical and socio-cultural contexts. And such perspectives were still
missing or lacking in the research area of South Asian immigrant women’s cancer screening. My research therefore used a critical feminist and antiracist approach to explore these immigrant women’s access to and experiences with the Canadian healthcare system in general and cancer screening services in particular. It attempted to produce more complex understandings of South Asian immigrant women’s engagements with cancer screening from their own perspectives, with a special focus on their experiences of migration, relocation and resettlement in Canada that are shaped by the complex intersections of their race, gender, age, class, generation, educational and immigration status.

I undertook a qualitative research to capture the lived experiences and complex realities of these women as shaped by multiple intersecting political, economic, historical and social structures and policies. A shift from the emphasis on South Asian culture to that on the challenges and stress of migration and settlement in a new country helped me gain a better understanding of the systemic racism and poverty, institutional, structural and socioeconomic barriers faced by South Asian immigrant women in accessing health care and other services. It produced a deeper knowledge of how these women’s gendered, racialized and classed experiences of migration and resettlement in Canada intersect to situate them into marginalized positions from where it becomes difficult to access health care, especially preventive health services such as cancer screening. A significant gap in this area of health research is that very few have explored the ways in which race, class, age, and gender relations intersect with immigration and settlement status to shape immigrant women’s experiences with cancer screening services. An intersectionality framework in the current research was timely and necessary in order to explore the broader contexts of South Asian immigrant women’s health, and particularly to uncover the complex interrelationships between the larger structures and these women’s subjective experiences of use or lack of use of breast and cervical cancer screening services. The lens of intersectionality was also needed to uncover how the historical as well as current policies, institutionalized practices and structural inequities in Canada interact with each other to marginalize these women in both discursive and material ways, thereby shaping their health and access to cancer screening services and other healthcare services.
Research Purpose and Questions

The broad purpose of my study was to understand women’s access to and experiences with cancer screening services within the broader political, economic, historical and social contexts of their lives. One of the main objectives was to explore and depict the complex and multiple intersecting influences on South Asian immigrant women’s access to cancer screening within the larger frame of their diverse life-contexts in Canada. I wanted to gain fresh insights about how these women’s experiences of migration and resettlement in a gendered, racialized and classed as well as a multicultural and neoliberal society in Canada play into shaping their use or lack of use of cancer screening services. In other words, my research aimed to look for the links between South Asian women’s access to healthcare system including the cancer screening services, and their socioeconomic and structural positions in Canada as shaped by the broader and interlocking systems and policies related to race, class, gender, immigration and health inequities. The ultimate goal was to enhance South Asian women’s access to not only cancer screening services, but the Canadian healthcare system in general, through influencing research, policy and practice towards reducing the socioeconomic, political and systemic inequalities leading to health inequities.

The following key questions guided the research and its objective to acquire more complex and deeper understandings about the women’s access to and experiences with cancer screening services:

1. What are the patterns and extent of South Asian immigrant women’s engagements with breast and cervical health, prevention, and screening of breast and/or cervical cancers?
2. What shapes these women’s use or lack of use of the breast and cervical cancer screening processes?
3. What are these women’s experiences with the healthcare system in general and the cancer screening processes in particular and how are their experiences related to immigration processes?
4. How do the broader systems, structures and policies in Canadian society shape South Asian immigrant women’s participation in and access to cancer screening services?
Original Contributions and Scopes of the Research

The research in hand has filled a number of gaps in the existent knowledge and scholarship about South Asian immigrant women’s health and access to health care, especially reproductive cancer screening. My research used a critical feminist antiracist approach and the lens of intersectionality, which has not been previously employed to understanding South Asian immigrant women’s access to and experiences with cancer screening services. Such an approach with its focus on structural issues and power relations that create health inequities, instead of that on an essentialist notion of culture, has produced a thorough and critical understanding of the issues concerning South Asian women’s access to cancer screening services, and has provided the much needed support to make structural changes that promote health equity and equitable access to health care. Vissandjee, Apale and Wieringa (2009) argued that although migration is increasingly being recognized as an important contributor to health and health iniquities among women in Canada, more extensive research is still needed to clarify the health effects of migration. The current project’s spotlight on these women’s diverse experiences of migration, integration and racialization not only produced new and more complex knowledge about South Asian women’s participation in cancer screening, but also about the general relationship or connection between immigration, health and access to health care for ethnic minority women.

The present study viewed the issue of access to health care beyond South Asian women’s cultural practices and personal attitudes and understandings about health, cancer and cancer screening. I examined these women’s access to cancer screening within the broader contexts of their overall experiences with the Canadian healthcare system – experiences that intersect with their immigration processes as well. Very few studies have considered South Asian women’s perspectives on the quality of cancer preventive care in examining the barriers to such services. I also viewed the issue from the perspectives of these women as rightful agents deserving equitable access to the state funded services including health care and cancer screening. This social justice approach and intersectionality framework allowed me to consider the issue of access from the perspectives and experiences of South Asian immigrant women within the larger contexts of their lives as well as within the historical and existing structural inequities of the Canadian society. The present study was also ground breaking in its adoption of an intersectional analysis of the issue of South Asian women’s access to cancer screening services.
As such, my research has made important theoretical and methodological contributions through using feminist antiracist theories and intersectionality paradigm in designing the research and interpreting the data. The use of intersectionality perspectives in exploring South Asian women’s experiences and access to health care helped to view the women as active agents rather than passive ‘victims’ of culture as well as other structural forces, and to resist their predominant representation as the cultural ‘other’ in the literature. I also tried to examine and understand ethnic minority or racialized women’s access to cancer screening and other health services from an intersectionality perspective rather than simply in contexts of the geographical, organizational and financial aspects of health services, or in terms of women’s personal understandings, attitudes, cultural beliefs and practices around health and illnesses. An exploration of how the Canadian immigration policies, multicultural discourses and neoliberal economic restructuring processes shape South Asian immigrant women’s access to cancer screening services showed that women’s personal health issues and access to health care cannot be understood as isolated from the larger social, political, historical, material and discursive contexts of their lives. I have offered a theoretical map (Figure 7.2) to show how South Asian immigrant women’s access to and experiences with cancer screening were shaped by the complex intersections of broader systems, structures and policies and their diverse impacts on women’s personal, material and everyday lives and on their interactions with physicians or healthcare providers. The intersectionality framework and analysis reflected the need to theorize the notion of health care access more critically and holistically as a process that reveals how gender, racialization, immigration and socioeconomic status, and historical as well as current positioning of South Asian women as the ‘other’ intersect to shape their participation in cancer screening and other preventive healthcare practices. Also equitable access to health care cannot be ensured simply through providing services, free of financial expenses, in a culturally sensitive manner without addressing the social, political, historical, material and structural inequities experienced by racialized immigrant and other women in Canada.

An exploration of South Asian immigrant women’s personal experiences as shaped by their historical and ongoing positioning as the ‘other,’ with the help of antiracist analyses and critiques of the Canadian immigration policies, multicultural discourses and neoliberal economic restructuring processes, facilitated the understanding of how the historical as well as current policies, institutionalized practices and structural inequities intersect with each other to shape
these women’s health and access to health care. Such a rich intersectional analysis should be useful in designing future research, policies and healthcare practices intended to bring about ideological, social and structural changes necessary for creating an equitable society and healthcare system in Canada. I have also offered some suggestions and recommendations for researchers, policy makers and health care and other service providers as to how to improve South Asian and other racialized women’s access to cancer screening and other healthcare services.

No studies are known to have looked at the common problems of South Asian women’s poor access to both breast and cervical cancer screening, or to have explored their participation in clinical breast examination and breast self-examination together with their use of mammogram and Pap smears. I examined breast and cervical cancer screening together because both are female cancers related to the reproductive system involving the most private parts of women’s body. Both practices are similar components of preventive health and should be studied together more frequently (Bryant, Browne, Barton and Zumbo 2002). Although these are rarely studied together, interestingly, literature on both types of cancer screening for South Asian women share a common culturalist and uncritical focus on women’s health beliefs and understandings, and cultural and language barriers. As such, the current study also addressed another significant gap in cancer preventative health research with South Asian women because it considered the common issues involved in accessing both breast and cervical cancer screening. However, I did not explore the healthcare providers’ perspectives on the issue, choosing instead to highlight the women’s standpoints.

In order to ensure equitable health care for immigrant and ethnic minority or other marginalized women, my research supports the removal of structural and systemic barriers, and calls for healthcare policies and primary healthcare practices that are framed both by an understanding of the complex material, everyday life practices of these women and by an analyses of the socio-political and historical processes beyond the clinic/healthcare system. And by doing so, this research contribute to the existing body of work informed by feminist antiracist and critical cultural perspectives, and enriched by the critiques of the multicultural, neoliberal and individualistic approaches to healthcare research and practice. Although I have used antiracist critiques of the cultural essentialism, cultural reductionist approach to health
research and culturally sensitive model of health service delivery, my research however, do not intend to completely throw out the notion of culture and its influence on health. Instead, viewing culture as a power relation co-constituted by multiple other intersecting power relations and inequitable social relationships, it recognized culture as one of the many important and intersecting social determinants of health.

**Organization and Overview of the Thesis**

Having outlined the general research context, background facts and information, purpose, questions and contributions, the rest of this chapter presents an overview of the thesis. Each chapter of the dissertation serves to illustrate the research in hand from its inception to gradual progression and conclusion. The next chapter is the review of relevant literature in which I situate my research within the larger field of immigrant women’s health and cancer screening research, and explain the rationale of the current study by identifying major gaps in the available literature on South Asian women and cancer screening. It also describes the theoretical and conceptual approaches informed by feminist antiracist theory and intersectionality perspectives that emerged in contexts of the existing work pertinent to the research topic, and shaped the research questions, design and analysis.

In chapter three, I outline the methodology and research method employed in the study. The chapter begins with a discussion of the philosophical underpinnings of particular methods including the ontological and epistemological issues around knowledge production. Then it illustrates the research design and procedure followed in generating and analyzing the data. It also unpacks the ethical dilemmas with a reflexive account of my own location within the research project, especially encountered in reporting and representing in this dissertation the voices of South Asian immigrant women involved in this feminist qualitative research.

Chapters four, five and six document the analyses and discussions of the research findings or data in light of the research questions. I demonstrate the varied levels of South Asian immigrant women’s participation in breast and cervical cancer screening processes in chapter four. I go on to discuss the various intersecting factors that influenced in a very complex way the
women’s use and lack of use of these services. Women’s experiences revealed that their participation in cancer screening was not simply a matter of their individual attitudes or cultural health beliefs. Among the multiple intersecting factors that shaped women’s various levels of utilization of cancer screening services, two of the systemic and structural issues including women’s gendered and racialized experiences of migration and settlement, and their experiences with the primary care contingent on physician practices, are explored and discussed in chapter five. In this chapter, I situate the issue of South Asian women’s cancer screening within the broader contexts of their migration, settlement, gender and health statuses and their general access to and overall experiences with the Canadian healthcare system. I discuss how women’s health and access to health care, including cancer screening, were shaped by their varied life circumstances and intersecting socioeconomic and settlement conditions as well as structural factors within and beyond the Canadian healthcare system. The analysis of women’s narratives showed that South Asian immigrant women encountered more than cultural and language barriers in accessing cancer screening services in Canada.

Chapter six presents an antiracist analysis, inspired by an intersectionality framework, about how the broader systems, structures and policies affect South Asian immigrant women’s status and position as the ‘other’ in Canada and shape their access to and experiences with the cancer screening and other healthcare services. I discuss the historical as well as current positioning of South Asian women as the ‘other’ with an overview of the Canadian immigration and multicultural policies and neoliberal ideologies. I also analyze the ways in which contemporary health care restructuring as informed by neoliberal discourses and policies govern clinical practices and affect South Asian women’s participation in Canadian healthcare system, especially reproductive cancer screening. I go on to discuss how the larger socio-political and discursive contexts influence women’s different levels of abilities and agencies to negotiate with the gendered division of labour and structural barriers embedded in health care and other systems in Canada, and to make certain health enhancing choices and actions.

The final chapter wraps up the key findings and arguments in light of the research objectives and questions, and by doing so, makes links between and among the research questions, findings and the earlier chapters. It also considers the broader theoretical, methodological and practical implications along with an acknowledgement of the limitations of
this work and some ideas for future research in the area. Lastly, in this chapter, I offer some suggestions and recommendations for South Asian women’s improved and equitable access to cancer screening and other healthcare services in Canada.
CHAPTER 2: REVIEW OF EXISTING LITERATURE

Introduction¹

A broad review of the existing literature pertinent to the current research topic is presented here. First, I locate South Asian immigrant women within women’s health research and within the studies of breast and cervical cancer screening. Then in context of the existing knowledge of South Asian immigrant women’s participation in cancer screening, a theoretical framework and methodological approach is developed in order to explore the research questions laid out with the broad objective of understanding South Asian women’s access to cancer screening services in the larger contexts of their immigration and settlement experiences. In other words, the research questions, objectives, theoretical and methodological perspectives used in the study are situated within and justified against the broader field of the study, particularly in view of some of the gaps in the existent knowledge about South Asian women’s cancer screening.

A range of literature is discussed in what follows – from South Asian and other immigrant or non-immigrant women’s general health issues in brief, to the issues of South Asian women’s cancer screening at length. I consider the antiracist work on South Asian and other ethnic minority women’s experience of health inequities and access to health care and other social services. I also examine the feminist antiracist theoretical frameworks along with the postcolonial theoretical perspectives, especially in relation to immigrant women’s health research. Also integrated in the discussion is a review of Intersectionality theory, with a particular focus on intersectionality and health scholarship, and of how the interactions among the systems of gender, race, class and immigration shape experiences of health inequities for South Asian women. These constituted the central conceptual or theoretical constructs used in

¹ Parts of this chapter have been published by the author (Habib, 2008) as “Culture, Multiculturalism and Diversity: A Feminist Antiracist Examination of South Asian Immigrant Women’s Utilization of Cancer Screening Services” in The International Journal of Diversity in Organizations, Communities and Nations 8, no. 4:187-196.
the current research. Also feminist and antiracist critiques of the Canadian state’s multicultural
and neoliberal approaches to health care and, of the culturalist framework used in healthcare
research and practices involving ethnic minority immigrant women are quite relevant to the
current research. These issues and critiques are discussed here, because they were central in
framing the research questions and shaping the analysis.

**Women’s Health Research and South Asian Immigrant Women**

Raphael (2004) noticed that significant inequities in health among citizens persist despite general
improvements in the health of Canadians since 1900. Although Canada has a relatively high
standard of living and health, and a publicly funded universal healthcare system, Varcoe,
Hankivsky and Morrow (2007) observed that considerable social and health inequities persist for
all women, and particularly for women disadvantaged by multiple forms of oppression. Egan and
Gardner (2004) pointed out that several studies found that immigrant, refugee and racial minority
women have obvious healthcare needs, but they utilize healthcare services at a significantly
lower rate than other women in Canada. First nations, refugee and visible minority women often
face racism, along with language and cultural barriers to maintaining health and accessing health
care (Anderson 2000; Anderson and Reimer Kirkham 1998; Anderson, Blue and Lau 1991;
Armstrong 2004; Dyck 2004). Along with other ethnic minority immigrant women, South Asian
women experience inadequate and inequitable access to health care and many other social
services (Agnew 1996, 2009; Bannerji 2000; Jiwani 2006; Thobani 2000; Varcoe, Jaffer and
Kelln 2002). While there is much recognition of the impact of socioeconomic inequities,
disproportionately suffered by racial minority immigrant and refugee women, on their health and
access to healthcare services, Vissandjee, Thurston, Apale and Nahar (2007) pointed out that
women’s experiences of migration were essentially invisible in health and migration research
throughout the 1960s and 1970s, and that recent research efforts are in the process of integrating
migration, especially the gendered experiences of migration as an important contributor to health
and health inequities among women. Women have long remained absent from history of
immigration and literature on South Asians in Canada (Agnew 1996). And South Asian women
only started to gain attention from feminist immigration and health scholars during the last few
decades. However, Vissandjee, Apale and Wieringa (2009, 190) insisted that more extensive
research is needed to clarify the health effects of migration, especially how the relationship between migration and health may be strongly influenced by the diverse experiences previous to, during, and after migration.

Feminist health researchers emphasize the importance of examining and understanding women’s health within the larger social, economic, cultural, and political contexts of their lives. As Ruzek, Olesen, and Clarke (1997) claimed, feminist models of health research place women at the centre of analysis and emphasize how gender as well as other social roles and rules affect women’s health. However, they admitted that such models have not always adequately addressed health issues of women whose life circumstances vary by race, class, or a variety of status characteristics, locations, or identities. So they called for research that would acknowledge and understand the complexities and differences in women’s health in a “multicultural society” in order to adequately address their inequitable access to health care as well as to other resources and working and living conditions that promote health. Similarly, Varcoe, Hankivsky and Morrow pointed out that a critical analysis of women’s health should not be limited to gender alone, “but rather [should] contextualize women in their diverse social and economic circumstances and understand gender as inseparable from other forms of social difference such as race, ethnicity, culture, class, sexual orientation, gender identity and ability” (2007, 3). On the other hand, Narayan (1998) pointed out that attempts in feminist scholarship to avoid gender essentialism, or universal generalization about ‘all women,’ are often replaced by an essentialist generalization about cultural differences between Western and non-Western cultures, which reinforces colonialist assumptions and stereotypes about ‘non-Western culture’ as ahistorical and homogenous – undifferentiated by class, ethnicity, language and geographical location. For example, through a critical textual analysis of the representation of Indian women in Canadian newspapers with respect to their use of reproductive technology, Henry found that South Asian women were stereotyped as “fatal victims of a ‘traditional,’ ‘unethical,’ and ‘violent’ culture” (2006, 245). Henry also argued that the racialized representation of South Asian immigrant women and the meanings produced through such representations reinforce various unequal social positions, such as “the Western ‘elite’ as ‘superior’ to Eastern and masses” (245). Thus ethnic minority women are often constructed or represented in health research as well as in immigration and multicultural discourses as the cultural ‘other’ in Canada, and viewed as a ‘burden’ on state-funded services (Agnew 1993; Razack 1998; Thobani 1999).
As feminist medical geographer Isabel Dyck (2004) noted, two major models have been used in analyzing the health status and health care access issues of minority immigrant groups: one accords primacy to culture and the other focuses on the socioeconomic and political marginalization of immigrants. Reimer Kirkham (2003, 764) also noticed that health care and nursing literature in Canada generally has been silent on matters such as inequities in health, marginalizing healthcare practices, racialization, and racism. Instead, there has been a pervasive tendency to focus on culture as an influence or barrier to health and illness in an effort to account for differences in health outcomes. However, feminist antiracist health scholars, such as Anderson (2000), Dossa (2004), and Jiwani (2006) have studied the impact of the structural and socially constructed relations of power on the health of immigrant women. As Anderson and Reimer Kirkham (1998) rightly argued, the absence and marginal positions of some groups within the so-called Canadian mosaic need to be examined in order to uncover the reasons behind the underutilization of the country’s health services by these marginalized people. They also suggested the importance of examining marginalized groups of people’s access to health care in broader socioeconomic and political contexts. Anderson and Reimer Kirkham (1998), and Browne, Smye and Varcoe (2007), among others, used antiracist and postcolonial feminist approaches to examine how the history of colonization and systemic racism in Canada shape immigrant and Aboriginal women’s access to healthcare services in the country. These scholars also emphasized the importance of examining how the organization of the Canadian healthcare system affects these women’s health and access to health care. Although there are several critical studies of immigrant women’s health, especially in the areas of mental health (Dossa 2004; Guruge and Khanlou 2004; Guruge and Collins 2008), violence against women (Agnew 1998; Jiwani 2001, 2006; Varcoe, Jaffer and Kelln 2002), and chronic illnesses and general health status (Anderson, Blue and Lau 1991; Anderson 2000; Dyck 1992, 1998, 2004; Vissandjee and Hyman 2011), other areas of health, such as reproductive health, preventive care and acute illness, tend to be ignored. These critical perspectives are relatively new and rather infrequently employed in mainstream health research on immigrant women and they have not been fully extended to the area of cancer screening and other preventive care. Instead, culture has become an easy explanation for immigrant and ethnic minority women’s underutilization of preventative healthcare services.
South Asian immigrant women’s health, especially breast and cervical cancer screening practices, are quite often viewed through a culturalist lens where culture seems to be the central focus and the core analytic tool of the research. A couple of relatively recent quantitative studies (McDonald and Kennedy 2007; Woltman and Newbold 2007), for example, took a culturalist approach by explaining the difference in uptake of cervical cancer screening by immigrant women in terms of their cultural origin or ethnicity. Such an approach reinforces cultural stereotypes and homogenizes these women’s experiences. It also ignores the processes of immigration, settlement, integration and racialization, and hides the racism and other systemic barriers in Canadian society and the healthcare system. A culturalist framework, as Jiwani powerfully argued,

[P]athologizes immigrant women of color from different ethnic backgrounds. At the backdrop of systemic and everyday racism, the focus on culture quickly becomes one of implicitly or explicitly comparing a backward, traditional, and oppressive cultural system to the modern, progressive, and egalitarian culture of the West. Such an approach again results in the production of cultural prescriptions or culturally sensitive approach that further reifies stereotypic representations of particular ethnic groups (2006, 161).

The antiracist literature on South Asian and other immigrant women’s lives and experiences indicates that various socioeconomic, political and structural processes place South Asian women as the ‘other’ into unequal and complex positions from where they are to access health care, including cancer screening services. But research on South Asian immigrant women’s participation in cancer screening largely remains more focused on cultural and language barriers, and still seems to lack any prominent antiracist and critical perspectives that explicate healthcare practices in broader political, economic, historical and social contexts. Furthermore, efforts to integrate the gendered experience of migration and its impacts on South Asian women’s health and access to health care are still absent in the research area of South Asian women’s use or inadequate use of breast and cervical cancer screening. Further research is required to explore whether and to what extent immigrant women under-utilize preventive services such as Pap smear and mammogram, due to systemic and structural barriers in and outside of the healthcare system, rather than only due to cultural differences in concepts of health, cancer and importance of cancer screening.
Existing Knowledge of South Asian Immigrant Women’s Participation in Reproductive Cancer Screening

In order to conduct a review of current knowledge in the area of South Asian immigrant women and cancer screening in Canada, I searched the literature and found rather limited number of studies as this is a relatively new area of research starting back in the early 1990s. It may be noted that the Screening Mammography Program of British Columbia was the first province-wide breast cancer screening program in Canada and has been operating since 1989 (British Columbia Provincial Health Officer 2003; Bryant, Browne, Barton and Zumbo 2002). Although BC was the first jurisdiction in the world to institute a screening program for cervical cancer using Pap smears in 1955 (British Columbia Provincial Health Officer 2003) research related to utilization of Pap smears by ethnic minority women seemed to be a relatively new field. Research on cervical and/or breast cancer screening seemed to have started in the 1980s, but the studies were done on general populations of women, which were presumably comprised primarily of white women. Research on specific ethnic groups of women became more common in the late 1990s. While my research remained centered around South Asian immigrant women’s participation in cancer screening in Canada, in some instances, studies that covered cancer screening more generally among immigrant or ethnic minority women in North America, and to a limited extent, in the UK, were also considered in the review of literature because the study findings and approaches seemed relevant to the topic of the current project.

Although considerable numbers of studies have analysed breast and/or cervical cancer screening among different groups of women and identified factors related to under/utilization of Pap smear and/or Mammogram by immigrant women of different ethnic backgrounds such as Chinese, Korean, Vietnamese, Filipino women in the US, UK and Canada, relatively few have examined the cancer screening practices of South Asian immigrants in particular in Canada and in the province of British Columbia. Generally two different types of research were identified in the area of South Asian women’s cancer screening. The first one consisted of quantitative analyses of population based health surveys involving large samples, often comparing the rates of cancer screening uptake among women of different ethnicities or national and cultural origins, ages, socioeconomic status, geographic or rural/urban locations and immigrant or non-immigrant backgrounds. Some have measured the level of acculturation and knowledge about reproductive
cancer and screening processes among South Asian women and their association with the level of utilization of the screening services. Such quantitative studies have clearly overlooked the voices and lived experiences of women. The second type included qualitative and ethnographic studies that have tried to understand cultural beliefs, expectations and values that influence health practices of South Asian women in attempts to uncover the culturally specific barriers and to ensure more culturally suitable ways to improve these women’s access to cancer screening services. Both quantitative and qualitative research alike generally have taken a rather culturalist approach in predicting, locating and interpreting the barriers to cancer screening services mainly in the light of South Asian and other ethnic minority women’s linguistic and cultural differences. The only known exception was a couple of qualitative studies by Bottorff et al. (2001) and Grewal, Bottorff and Balneaves (2004) which shifted the main focus from cultural barriers to the structural issues and challenges in establishing and maintaining a community based specialized women-centered Pap test clinic for South Asian and other Asian immigrant and First Nations women. But the literature also has completely ignored the complex perspectives and realities of South Asian women’s lives in Canada – realities that are shaped by their gendered, classed and racialized experiences of immigration and settlement. Relatively few studies have examined determinants of both Pap test and mammography together, which Bryant, Browne, Barton and Zumbo (2002) identified as a gap in preventative health research. Considering that both practices are similar components of preventive health, they insisted that these should be considered as equal and related components of preventive health. However, the main observations and findings of the review of existent research could be categorized into the following themes: rates of participation in cancer screening, determinants of participation in cancer screening, culture and South Asian women’s cancer screening, South Asian women’s cancer screening and the Health Belief Model, removing barriers and enhancing access to cancer screening.

**Rates of Participation in Cancer Screening**

Published and conclusive findings about South Asian women’s cervical and breast cancer prevalence, mortality and survival rates in Canada are quite scarce; however, there is sufficient data to clearly indicate their low rate of participation in cancer screening processes. Although there is limited data available to show that the incidence of cervical cancer is any higher among South Asian women living in Canada compared with non-South Asian women, the literature
suggests that cervical cancer in immigrant women in general, is less likely to be detected early than it is in the general population, because immigrant women tend not to take advantage of screening (Oelke and Vollman 2007). Ogilvie et al. (2004) found that women with low socioeconomic status, visible minority and immigrant women in Canada were over represented among women with cervical cancer and also had higher rates of non-attendance for screening Pap smear and colposcopy services for follow up of abnormal Pap smears. Recommended cervical cancer screening was significantly lower among women who were older, living in low-income areas, or recent immigrants in Toronto, Canada (Lofters, Moineddin, Hwang and Glazier 2010). A population based study by Lofters, Hwang, Moineddin and Glazier (2010) compared the use of recommended cervical cancer screening among screening-eligible immigrant and native-born women in Ontario, Canada between 2006 and 2008. And the study found that screening rates were lowest among women from South Asia, especially older women living in the lowest-income neighbourhoods and not included in a primary care enrolment model, when compared to the Canadian-born women and immigrants who lived in Canada for 25 or more years. Also, women from South Asia, the Middle East and North Africa were the most vulnerable to lack of screening.

The incidence of invasive cervical cancer was reported by Hislop, Mumick and Yelland (1995) to be 1.5 – 4.5 times higher for South Asian women over the age of 34 years, compared to all women in the province of British Columbia, Canada. A more recent study by Hislop, Bajdik, Regier and Barroetavena (2007) found that while survival rates for female cervical cancers have improved over time in Chinese and South Asian women as compared to the BC general population, South Asian women still had a lower survival rates for cervical cancer as compared to Chinese and all other BC women. One of the potential explanations of the differences in the observed survival rates was the variations in screening and early detection. In general, immigrant, less educated and single women were found to be more likely to have never had a Pap test in Prince George of British Columbia (Bryant, Browne, Barton and Zumbo 2002). BC Provincial Health Officer’s Annual Report (2003) published that in 2000/01, about six in ten BC women, age 20 to 69 years had a Pap smear in the last thirty months and that some women, particularly Aboriginal women, recent immigrants and women from low-income households, have lower than average participation rates. Thus Grewal, Bottorff and Balneaves (2004) seemed to have rightly recognized that South Asian women are at high risk for invasive cervical cancer
and that the clinically observed high incidence of invasive cervical cancer among South Asian women in British Columbia may be related to their low participation rates in cervical cancer screening programs.

Canadian data on South Asian women’s breast cancer incidence and mortality rates are even more limited than those on cervical cancer. Some relevant and broad information about breast cancer incidence and mortality of South Asian and Asian women in general in other countries were identified. Breast cancer was reported to be one of the most frequent cancers among Asian Indian women living in India (Sadler et al. 2001). Moreover, one recent study showed that the incidence of breast cancer in Asia is rising and is associated with increased mortality while in the West although the incidence is increasing, the mortality rate is decreasing (Leong et al. 2010). On the other hand, South Asian immigrants in the US as well as in the United Kingdom and Canada have been found to have lower rates of cancers of all types compared to the native born population; however, for breast cancer, Caucasians were found to have slightly better survival rate than Asian Indians and Pakistanis in the US (Goggins and Wong 2009). Survival after breast cancer was also found to be poorer among first generation Chinese, Japanese, Filipino, Korean, Vietnamese, and South Asian immigrant women compared to US-born Asians (Scarlett et al. 2010). In Canada, however, Hislop, Bajdik, Regier and Barroetavena (2007) found that South Asian women had similar survival rates to all BC women for breast cancer as the female breast cancer survival rates have improved over time in Chinese and South Asian women.

Although breast cancer is the most commonly diagnosed cancer among North American women, breast cancer screening programs are underutilized by ethnic minority women in North America (Ahmad and Stewart 2004). Bottorff et al. (1998) noted that data regarding the incidence of breast cancer among South Asian women living in Canada is limited, but there is some evidence that South Asian women are not excluded from the risk of getting breast cancer. A few studies have reported low breast cancer screening rates among South Asian immigrant women in Canada (Choudhry, Srivastava and Fitch 1998; Gupta, Kumar and Stewart 2002). Monthly breast self-exam adherence rates among 57 first generation immigrant women aged 40 and over from India and Pakistan in Toronto were reported to be 12%, while 49% had undergone at least one clinical breast exam during their lives; however, 47% had never had a mammogram
(Choudhry, Srivastava and Fitch 1998). BC Provincial Health Officer’s Annual Report (2003) showed that despite the increased participation rate from 44% in 1998 to 49% in 2001 among women age 50 to 74 years, the province was still far from reaching the recommended 70% participation rate. Only 39% of women in BC aged 70 to 79 and 50% of those aged 60 to 69 years had a screening mammogram in 2000/01. Considering the literature on South Asian women’s inadequate participation in screening, this seems to be an important health problem for South Asian women in Canada.

**Determinants of Participation in Cancer Screening**

The extant literature indicates that participation in cervical and/or breast cancer screening following immigration is influenced by complex and interacting factors including limited experience with and knowledge of testing, lack of knowledge about cervical and/or breast cancer, language barriers, and cultural beliefs and values that influence health practices (Grewal, Bottorff and Balneaves 2004). Some structural factors within the Canadian healthcare system (such as gender and ethnicity of physicians, lack of referral from a physician) have also been found to be important in the context of Pap testing (Bottorff et al. 2001). Other dynamics found to be influencing women’s receptivity to Pap testing include the combined effects of ethnicity, gender, social class and values, women’s beliefs and values related to Pap testing, and the influence of other health and social concerns on women’s likelihood of engaging in screening behaviours such as Pap testing (Bottorff et al. 2001). Very little research has examined how the complexities and intersectionalities of various structural and ideological processes and discourses, and broader socioeconomic policies shape South Asian immigrant women’s engagement in cancer screening. A few studies have examined migration as a predictor of low cervical cancer screening, but migration is understood only in terms of length of stay.

Several demographic and socioeconomic factors such as age, educational status and income of women have been associated with the participation of South Asian and other ethnic minority immigrant women in cancer screening. Ahmad and Stewart (2004) pointed out that several large-scale North American survey studies examining the relationship between demographic variables and participation in screening have reported that higher education and income increase women’s likelihood of having breast or cervical cancer screening while
increasing age decreases the likelihood of clinical breast exams. Lofters, Moineddin, Hwang and Glazier (2011) found that although many international studies have shown older age to be associated with lower rates of cervical cancer screening among both immigrants and the general population, they found that being younger than 35-49 years and living in the lowest-income neighbourhoods were related to screening disparities for immigrant women. On the other hand, Choudhry, Srivastava and Fitch (1998) found no statistically significant association between South Asian women’s age, education, or mother tongue and the breast health practice scores in Toronto although proficiency in English language and number of years in Canada had a significant relationship with the breast health practice scores.

Results of quantitative studies based on analysis of large scale population health survey data have found important associations between length of stay since immigration and immigrant women’s use of cancer screening services. A number of studies found a markedly lower use of Pap smear testing among recent immigrant women, especially among those of South Asian and other Asian backgrounds (Lofters, Moineddin, Hwang and Glazier 2010; McDonald and Kennedy 2007; Woltman and Newbold 2007). Lofters, Moineddin, Hwang and Glazier (2010) observed that within a system of universal health insurance, cervical cancer screening was significantly lower among women who were recent immigrants, older or living in low-income areas. On the other hand, Gupta, Kumar and Stewart’s study with South Asian women (2002) found that a low level of acculturation, rather than simply shorter length of residence, was a more important characteristic of women who underutilized and demonstrated low knowledge of Pap testing. McDonald and Kennedy’s (2007) study found that most immigrant women exhibited increasing usage rates for cervical cancer screening with years since migration, except for women of Asian backgrounds; this finding held even for second-generation Asian Canadians and those who arrived as children. Even though such survey data cannot actually identify the causal factors behind low Pap smear testing rates exhibited by immigrant and ethnic minority women, the authors assumed that social or cultural factors, rather than access barriers, underpin the lower utilization rates for immigrants of Asian ethnicity, because second-generation immigrants and immigrants who arrived as children were less likely to encounter other access barriers (e.g., lack of English skill or familiarity with the system). Similarly, some immigrant women’s cultural origin (such as, South Asian, Chinese and other Asian) was predicted by Woltman and Newbold (2007) as the factor creating a difference in those women’s uptake of cervical cancer screening
from other immigrant and non-immigrant women. Such culturalist explanations of potential barriers to cancer screening faced by ethnic minority immigrant women fail to take into account the broader contexts of their lives (such as race-based discrimination in health care, social, education and other settings) and the financial and other challenges faced by non-white recent immigrants.\(^2\)

However, a number of qualitative studies reported limited breast health knowledge among South Asian immigrant women. And limited use of breast health practices has been shown to be related to not only a lack of knowledge about and access to screening facilities, but as well to particular cultural beliefs and values that tend to influence health practices among South Asian women. Choudhry, Srivastava and Fitch (1998) explored knowledge, attitudes, beliefs, and practices regarding breast cancer detection practices among South Asian women in Toronto and found that overall, women with minimal knowledge of breast cancer in that study did not engage in breast cancer detection practices. Gupta, Kumar and Stewart (2002) examined the knowledge and use of Pap smears in South Asian women in Canada, and whether the level of acculturation or formal education among these women influenced their knowledge and use of Pap smears. Low levels of knowledge about the Pap test and a low prevalence of Pap testing behaviour were significantly correlated with a low level of formal education, education taking place outside of Canada, and a low index of acculturation.

Several studies on South Asian immigrant women have revealed certain culturally based norms, beliefs and values likely to hinder their uptake of breast cancer screening (Ahmad, Cameron and Stewart 2004; Bottorff et al. 1998; Choudhry et al. 1998; Johnson et al. 1999). Findings from the study by Bottorff et al. (2001) suggested that these cultural beliefs inform decisions about whether to engage in screening behaviours, when to seek medical advice, and which treatments to accept. Bottorff et al. maintained that participation in screening in the

\(^2\) Although whether second generation visible minority women face any special or different barriers to accessing cancer screening services than first generation women is beyond the scope of the current research, a 2011 report in the *Globe and Mail* stated the racialization and discrimination faced by Canadian-born visible minorities and those migrating to Canada as young children who earn less than their similarly qualified white counterparts (Friesen 2011).
absence of symptoms does not readily fit with South Asian women’s holistic views of health and health promotion. Several studies (Bottorff et al. 1998; Choudhry, Srivastava and Fitch 1998; Johnson et al. 1999) also stated that South Asian women tended to seek advice from health professionals or engage in breast screening practices if they had symptoms, were particularly worried or were instructed to do so by others. Other studies described many South Asian women’s strong beliefs about cancer as a stigmatizing, painful, and untreatable disease (Choudhry et al. 1998; Johnson et al. 1999). Such beliefs deter them from participating in cancer screening and make it difficult for women to readily accept healthcare professionals’ concerns about early detection of cervical cancer (Bottorff et al. 2001). Ahmad and Stewart (2004) reported that breast cancer was viewed by South Asian women in their study as a disease that would not affect them. Other qualitative studies (Bottorff et al. 1998; Johnson et al. 1999) with South Asian immigrant women also described their low perceived risk of breast cancer and high fear, fatalistic beliefs, belief in inevitability of suffering due to fate (karma), and embarrassment in undergoing sensitive physical examinations. These cultural beliefs, misperceptions and limited knowledge have been suggested in these studies to be barriers likely to hinder women from performing or seeking breast or cervical examinations. While offering important information, such a narrow focus on cultural barriers obviously tends to overlook how immigration, structural and healthcare system related factors also influence health seeking patterns of marginalized and racialized immigrants.

Some studies have looked at barriers rooted in the healthcare system and how factors such as language barriers, gender and cultural origin of the family physician performing the Pap test influence cervical cancer screening among South Asian immigrant women in Canada. Health care related factors, such as not being registered in a primary care patient enrolment model, and having either a male family doctor or a family doctor from the same country of origin were independently associated with lower rates of screening for immigrant women across most or all regions of origin including South Asia, suggesting that these variables tended to negatively affect screening for immigrant women regardless of their cultural or ethnic origin (Lofters, Moineddin, Hwang and Glazier 2011). The lower proportion of female practitioners in the medical profession has been implicated with lower use of health services including cancer screening by women who prefer female physicians. Ahmad, Gupta, Rawlins and Stewart (2002) pointed out that several studies on women’s preventive health behaviours such as breast and cervical cancer
screening demonstrated that women’s lower compliance and/or satisfaction with the recommended medical services depended on the male gender of the physician. A qualitative descriptive study by Oelke and Vollman (2007) found that health-provider issues such as, physician’s gender, language barriers, lack of trust and confidentiality, along with other factors such as lack of knowledge about the importance of prevention and influence of family and community affected South Asian Sikh women’s access to cervical cancer screening in urban areas in Alberta. Physician recommendation has been found to be the primary predictor of regular participation in mammography screening among ethnic minority, immigrant and Aboriginal women to the point that it is likely to overcome many of the factors associated with low participation, including socioeconomic factors (Johnson et al. 1996; Bryant, Browne, Barton and Zumbo 2002). Johnson et al. (1999) pointed out that common barriers that have been found to prevent South Asian women’s participation in breast screening programs include language, cultural beliefs, low socioeconomic status and the lack of referral from a physician. Bottorff et al. (2001) found that South Asian women do not consistently receive a physician’s recommendation even though there is evidence that such recommendation for Pap testing is highly influential in South Asian women's participation in cervical cancer screening (Choudhry, Srivastava and Fitch 1998; Johnson et al. 1999). This was also confirmed in Oelke and Vollman’s (2007) study with Sikh South Asian women who reported that their physicians were not informing them about the Pap test and its importance.

Thus Bottorff et al. (2001) realized that South Asian women’s access to Pap testing was not only restricted by their health beliefs and cultural values, but influenced by a complex interplay between cultural issues and structures within the healthcare system. Their study illustrated that the barriers embedded in opposite-gendered interactions and the gendered structures of the medical system complicate women’s access to Pap testing because under the current fee-for-service model of reimbursement for cervical screening, the majority of Canadian women are limited to receiving their Pap tests from family physicians, oftentimes a male physician (Bottorff et al.). Therefore, in BC a specialized Pap test clinic specifically for these women was started as a joint community project sponsored by local health authorities in May 1995 in response to high rates of cervical cancer within the South Asian population (Grewal, Bottorff and Balneaves 2004). Efforts were made to ensure that the clinic provided health services in a sensitive and culturally appropriate manner by female Punjabi/Hindi-speaking
nurses or physicians. To ensure physician support for the clinic, the mandate of the South Asian Pap Test Clinic was limited to breast and cervical cancer screening, and results of the Pap tests were forwarded to women’s family physicians who remained responsible for follow-up care and treatment. But structural factors within the Canadian healthcare system were found to create challenges in maintaining the specialized screening programs. The authors reported that not only were there very few female South Asian family physicians in the community, but there was also a reluctance by some male physicians to refer their patients to female physicians because of concerns about losing patients to another physician’s practice. In addition, other female healthcare providers (e.g., nurses) who could potentially offer cervical screening did not have billing privileges. The end result was that many South Asian women were not told about Pap test screening or provided with an acceptable alternative for obtaining this health service.

The BC Provincial Health Officer’s Annual Report (2003) pointed out that one factor underlying the lower than desirable participation rate of breast screening may lie in the continued high profile scientific debate about the relative merits of mammography screening which has been highly controversial and confusing for both the medical community and women in general. But no research so far has explored this issue and particularly how it may impact participation of South Asian women in breast cancer screening. Physicians’ perspectives and barriers encountered by health professionals in conducting Pap test and clinical breast exams for South Asian women have not been adequately investigated either. Again, very little research has explored how the broader structures and policies related to immigration, socioeconomic and political integration of immigrants and healthcare reform shape women’s participation in cancer screening. No attention is paid to the complex and intersecting processes through which various factors such as immigration category, age, financial in/stability, education level and English skills at the time of immigration, access to employment and other resources shape the experiences of immigrants and challenge and/or facilitate their access to cancer screening services. Further research, especially with a critical feminist and antiracist framework, still seemed to be needed to bring the gendered and racialized processes of immigration and integration to the center of analysis in order to improve South Asian immigrant women’s access to quality health care including cancer screening, and as well, to further counter the culturalist and essentialist approach predominant in this field of research and scholarship.
Culture and South Asian Women’s Cancer Screening

In much of the existing literature on South Asian women’s use of cancer screening, culture is understood in an essentialist way and framed as the main reason for their lack of utilization of these services. A cultural reductionist approach overemphasizes cultural determinants and hides structural inequities and power relations. For example, according to one study,

A nurse’s understanding of culture influences effectiveness of health teaching...[and] little is known about how culture affects their [South Asian immigrant women’s] health practices [related to breast cancer detection] (Choudhry et al. 1998, 1699, emphases added).

Culture, here, is deemed the determinant of health practices abstracted from the broader social, economic, historical, political and structural factors. Culture in this way is viewed as fixed in “a timeless and unchangeable vacuum outside of patriarchy, racism, imperialism, and colonialism” (Razack 1994, 896). Another study overemphasizes the importance of culture in advocating culturally sensitive care:

It is widely recognized that health beliefs differ across cultural groups and that health professionals, if they are to provide appropriate health care, need to be cognizant and sensitive to the diversity of these beliefs (Johnson et al. 1999, 243, emphases added).

This exemplifies the “essentialization of culture” which assumes that every culture has an essence that defines it and that every culture is homogeneous. It also focuses on differences between or across supposedly internally coherent groups ignoring internal variations within cultural groups based on gender, class, age, ability, sexuality and other dimensions, and maintains “the idea of consistent and coherent cultural groups with defined sets of beliefs and health behaviours” (Culley 2006, 150). In a similar fashion, “South Asian” (as well as Chinese and Asian) has been represented in the following example as merely a cultural identity, and such cultural origin has been explained as the factor creating the difference in uptake of cervical cancer screening. It also underscores the importance of information and awareness (rather than removal of structural inequities of gender, racialization and poverty), a common feature of culturally sensitive care:

[A] woman’s immigrant status and cultural origin appear to be significantly associated with ever having had a Pap test. In particular, the uptake of cervical cancer screening is less common among recent immigrant women and women of Chinese, South Asian and other Asian backgrounds...Findings point to the role of cultural origin, which largely
accounts for these differences... This indicates the need to promote greater information and awareness of public health services for cervical cancer screening, especially among recent immigrant women with such backgrounds (Woltman and Newbold 2007, 470, emphases added).

Such a culturalist approach decontextualizes immigrant women’s lives and overlooks their gendered experiences of migration and everyday racism, and as well the discriminatory and racialized practices within health care and other institutions in Canada. The very absence of the notion of racialization, and the centeredness of the term culture within the literature and discourse of South Asian women’s breast and cervical cancer detection practices seem to perpetuate the “culturalization of racism” – a process whereby the notion of cultural inferiority established on the basis of socio-cultural and technological inadequacy or “backwardness” is utilized to appropriate racism and sexism (Razack 1998). Within such discourse, culture is viewed as the barrier to equitable and effective healthcare service delivery, and South Asian women are viewed as a “challenge” creating special problems or requiring special attention and solutions. For example, in the following excerpt, “South Asians” are constructed as the problem:

The growing South Asian community in Canada creates challenges in providing health services, and this has been the stimulus for research to understand the health needs and health-seeking practices of this community (Grewal et al. 2005, 243, emphases added).

In this way, white Western culture is constructed as the standard against which the needs and health-seeking practices of the “other” are to be judged and understood. Thus, the following excerpt advocates the importance of research that can help understand the cultural beliefs and practices (of the ‘other’) around particular health issues (such as breast health) so that “culturally suitable health care” can be provided:

It is vitally important that factors such as ethnicity and cultural differences not preclude women from seeking and engaging in breast health practices. Indeed, we must ensure that services and educational messages are offered in culturally suitable ways (Bottorff et al. 1998, 2076, emphases added).

The prevailing literature also recognizes South Asian immigrant women’s lack of proficiency in dominant languages and cultures (English and French) as a crucial roadblock to accessing health care and therefore, advocates for dissemination of information about these services in the languages of these women and in a culturally appropriate manner. While these are important to ensuring better accessibility of healthcare services, the state’s bilingualism and
multiculturalism policies (which seem to contradict each other) also need to be questioned. Bilingualism has established English and French as the two official languages in Canada and in effect, has relegated all other languages of the minority people as an unofficial or cultural matter, hence under the umbrella of multiculturalism (Bannerji 2000).

The extant research on the barriers to South Asian women’s access to cancer preventive services, thus seem to use an under-theorized concept of culture that fails to grasp that “culture is complex, diverse, and grounded in social and political contexts” (Krane 2001, 406). Moreover, a central focus on these women’s cultures seems to construct them as the ‘multicultural other’ in Canada. In fact, such an approach is likely to maintain stereotypes about these supposedly ‘traditional’ women, and present them as a ‘problem’ or ‘challenge’ to mainstream healthcare service providers. A few studies have examined whether the lack of knowledge and use of Pap testing among South Asian and other ethnic minority immigrant women is related to a low level of acculturation. The notion of acculturation assumes that immigrants are supposed to adopt Canadian values or lifestyle after living a certain period of time in Canada. But the concept of acculturation imagines the bounded-ness and distinctiveness of South Asian and Canadian culture, and also views white European culture as the benchmark for understanding or measuring ‘other’ cultures. Not only does it reflect an assimilationist approach to understanding women’s access to health care, but also underestimates the structural and systemic barriers to ethnic minority women’s socioeconomic integration and access to healthcare system in Canada.

South Asian Women’s Cancer Screening and the Health Belief Model

Much of the research on South Asian and other ethnic minority women’s participation in cancer screening is heavily focused on understanding and controlling health behaviour of individuals or communities. Such research has predominantly used the Health Belief Model (HBM). Based on theories of health behaviour and originally developed by social psychologists in the US, this model tends to theorize how people’s beliefs about whether or not they are susceptible to disease, and how their perceptions of the benefits of trying to avoid it, influence their readiness to act (National Institutes of Health 2005). As a widely used model for health promotion and research, it attempts to address problem behaviours or risk factors that evoke health concerns (e.g., high-risk sexual behaviour and the possibility of contracting HIV) and design both short-term and
long-term behaviour change strategies (National Institutes of Health). Health motivation is its central focus and it can be particularly useful for developing strategies to deal with noncompliance in individuals (National Institutes of Health). The HBM has frequently guided nursing research in an attempt to increase knowledge of health-related behaviours, but the social behaviourist approach of this model does little to examine power issues (Thomas 1995).

The HBM has been used explicitly in a number of studies (e.g., Ahmad and Stewart 2004; Ahmad, Cameron and Stewart 2004; Choudhry, Srivastava and Fitch 1998; Johnson et al. 1999) to examine and understand how South Asian immigrant women’s beliefs and knowledge about and attitudes towards breast and/or cervical cancer and cancer screening methods such as Pap smear or breast self-exam are influenced by their culture, and how these cultural beliefs impact their health behaviour and practices. These cultural beliefs and understandings are viewed as factors that influence the women’s engagement in cancer detection and prevention practices. For example, one study (Johnson et al. 1999, 243) states, “One of the most powerful factors that influence health beliefs is culture.” As it signifies the importance of examining health beliefs –

Beliefs about symptoms, diseases, and health have a strong influence on how individuals make sense of their vulnerability and respond to illness ... Their [women’s] explanations inform their perceptions of risk for breast cancer and the type of action that they would take to minimize risk ... Perceptions of risk, in turn, influence health-seeking behaviour and compliance with recommendations (ibid., 251 – 252).

Such research focuses on identifying and improving individual health behaviours influenced by culturally specific perceptions of risk factors. In fact, the HBM is based on individual health behaviour theories that seek to interpret or analyze health behaviours at the individual level, and emphasize the rationality of a patient’s behaviour assuming that he/she can freely and successfully take a recommended health action (DeBarr 2004). Thus such research emphasizes improving awareness and motivating individuals to adopt healthy behaviours rather than creating environments and social changes that support healthy lifestyles and health practices, especially for those belonging to the margin (Anderson 1996). And the ways in which individual health behaviours become strongly influenced by social structures, norms and policies are generally overlooked.
**Removing Barriers and Enhancing Access to Cancer Screening**

Most studies that related South Asian women’s cultural knowledge, beliefs, values and understandings with their lower than expected level of utilization of cancer screening services, recommended culturally appropriate care and increased health literacy about cancer and cancer screening for these women in order to enhance their participation in breast and cervical screening. Bottorff et al. (1998) examined breast health practices from the perspective of South Asian women to provide a foundation for the development of culturally suitable breast health services for this group. Similarly, Johnson et al. (1999) recommended developing culturally suitable counselling strategies through informing practitioners about how culture influences women’s explanations about cancer or breast cancer in particular. They believed that a study focusing on the beliefs of South Asian women regarding breast cancer could inform the development of strategies to improve participation in breast health practices. A number of studies (Ahmad and Stewart 2004; Choudhry, Srivastava and Fitch 1998; Gupta, Kumar and Stewart 2002) highlighted the need for educational interventions on breast cancer and screening directed to South Asian and other ethnic minority and recent immigrant women in Canada. Ahmad and Stewart (2004) suggested community education among South Asian recent immigrant women about early detection of breast cancer through screening and effective health promotion initiatives to address women’s perceived barriers to motivate their uptake of breast cancer screening. While Choudhry, Srivastava and Fitch (1998) suggested that South Asian immigrant women be better informed about breast cancer and the benefits of breast cancer detection practices, Ahmad and Stewart (2004) recommended that healthcare providers try to enhance their efforts toward promotion of preventative health examinations, including clinical breast exam among South Asian women. Ahmad, Cameron and Stewart (2004) advocated and evaluated socio-culturally tailored intervention to improve knowledge, beliefs and clinical breast examination among South Asian immigrant women. The intervention comprised a series of socio-culturally tailored breast-health articles published in Urdu and Hindi community newspapers. The results of their study were reported to have supported the effectiveness of written socio-culturally tailored language-specific health education materials in promoting breast cancer screening within the targeted population. Lofters, Moineddin, Hwang and Glazier (2011) emphasized that targeted patient education campaigns should particularly focus on younger and older women and women of low income.
On the other hand, a few studies recommended changes in the healthcare system and removing structural barriers rather than just increased awareness and targeted cancer control for improving screening rates among South Asian immigrant women. Lofters, Moineddin, Hwang and Glazier (2011) stressed the importance of interventions within the healthcare system, and called for efforts to ensure that immigrant women get connected with the healthcare system after arrival and find a regular source of primary care. They also suggested that settlement agencies may play a substantial role toward this goal. A centrally organized Pap smear screening system with periodic invitations instead of the current system of opportunistic screening, as Lofters, Moineddin, Hwang and Glazier insisted, might also be beneficial for increasing screening rates among under-users. While there is a shortage of female family physicians preferred by many immigrant women, these authors suggested that some primary care models may also make it feasible for male physicians to have female nurses, physician assistants or nurse practitioners available to provide cervical cancer screening. This point has been reiterated by Bottorff et al. (2001) as they thought the use of clinics staffed by nurse practitioners could be valuable for providing preventative health care or cancer screening to women in ethnic minority groups. Lofters, Moineddin, Hwang and Glazier prescribed targeted education campaigns for physicians trained abroad because they found a lower screening rate among ethnic minority immigrant women when a physician and patient had the same ethnicity, although future research is needed to explore the underlying issues.

After studying the systemic challenges encountered in the South Asian Pap Test Clinic set up to increase the participation of immigrant women in screening practices, Grewal et al. (2004) came to the conclusion that access to Pap testing extends beyond simply providing culturally acceptable services. Bottorff et al. (2001) also maintained that while the establishment of special Pap test clinics for ethno-cultural groups seemed to have the potential to enhance participation of minority women in cervical screening, changes in health policy and the structures of health services are required to fully implement a women-centered health care. Clinical interactions that signify respectful encounters reflecting ethical values related to equality and the uniqueness and dignity of the individual were observed by Bottorff et al. to be important in women-centered care for ethno-cultural groups. And therefore, they realized, such care and service extend beyond cultural sensitivity. Both of these studies on the special ethno-cultural Pap test clinic echoed the important roles nurses can play in mobilizing and maintaining
collaborations with physicians as well as women, an essential factor to the continuing success of community-based programs.

In summary, the review of current literature reflected that South Asian immigrant women experience a number of barriers to accessing Pap smear and mammography screening and that interventions are required at multiple levels – from changing individual health behaviours to creating equitable and health enhancing policies and structures. In other words, simply understanding “the complexity of South Asian women’s beliefs” and sensitivity to these “women’s cultural understandings and beliefs” (Johnson et al. 1999, 253) will not suffice – structural changes are required to ensure equitable health care for all women.

**Developing Theoretical and Conceptual Frameworks**

A comprehensive review and analysis of the current literature revealed the level and extent of South Asian immigrant women’s engagement in cancer screening, the various determinants of their poor participation, the conceptual and methodological approaches used in studying and understanding the barriers to their equitable access to cancer screening and the suggested ways to remove those barriers. It also pointed to the gaps in the extant knowledge, and to the areas that demand further research and investigation. Although a few studies considered some structural factors and systemic issues within the Canadian healthcare system in examining South Asian women’s cancer screening, further research is needed to critically explore how the broader structures, policies and processes both within and outside the healthcare systems shape South Asian immigrant women’s participation in and access to cancer screening services. South Asian immigrant women’s access to and experiences with the broader Canadian healthcare system have not been adequately linked to these women’s engagement in cancer screening. And the diverse effects on South Asian women of the gendered and racialized processes of migration and socioeconomic integration into Canada have not been considered within the scholarship of their participation in breast and cervical cancer screening.

Antiracist scholars have connected the issue of racialization of immigrant women with the broader policy of immigration, integration and multiculturalism. Immigrant women’s health issues have also been linked with these broader policies and structures within such critical
scholarship. But such discussions have been absent in the literature of South Asian women’s access to cancer screening. Therefore I felt the need to use critical feminist works on immigrant and minority women’s health issues in examining South Asian women’s cancer screening, and to relate those works with the topic of the current study. My study was also informed by some general antiracist and feminist theories that may not be directly related to health or to immigrant women’s health but are useful for shedding light on the broader structural issues and policies that influence South Asian immigrant women’s experience of health inequities and inequitable access to quality health care. These theories and literature helped contextualize South Asian women’s cancer screening practices within the broader intersecting structures and processes of patriarchy, migration, poverty and racialization. For example, I have presented in Chapter Six an analysis of how the Canadian immigration and multicultural policies and neoliberal ideologies shape the historical and current positioning of South Asian immigrant women as the ‘other’ and how their status as the ‘other’ influences their access to health care and other services including cancer screening. I have included this discussion in Chapter Six instead of integrating it in the review of literature because I tried to connect the empirical data or the experiences of South Asian women with the historical as well as current policies and discourses that organize the material conditions for the very presence of South Asian women in Canada and the everyday lives including health issues of individual South Asian women – for the sake of an intersectional analysis and understanding of the issue. An exploration of South Asian immigrant women’s personal experiences as shaped by their historical and ongoing positioning as the ‘other,’ with the help of antiracist analyses and critiques of the Canadian immigration policies, multicultural discourses and neoliberal economic restructuring processes, facilitated the understanding of how the historical as well as current policies, institutionalized practices and structural inequities intersect with each other to shape these women’s health and access to health care.

Thus the current research employed feminist antiracist theories with an intersectional approach to explore how the processes of racialization intersect with gender, age, class and immigrant status in the everyday lives of South Asian immigrant women, and how the complex intersection of these factors situates them in marginalized, disadvantaged and stigmatized positions of the ‘other’ from where it becomes difficult for them to access healthcare services in general and cancer screening in particular. The next sections elaborate the central concepts and theories that shaped the designing, execution and analyses of the current research.
Critical Feminist and Antiracist Theories

Feminist and critical perspectives help us understand how women’s health and illnesses are embedded in complex layers of contexts, especially how socioeconomic and structural inequities determine the health and healthcare experiences of marginalized and racialized men and women (Anderson 1996). A critical feminist approach critiques the traditional biomedical model of health and the neoliberal approach to health care, and also challenges culturalist explanations of health conditions, health practices and health inequities. Such an approach works to contextualize health and health care within complex material, political, ideological and historical forces. Antiracist theories focus on how racism and power hierarchies operate both within and outside healthcare institutions, and they challenge Western biomedicine’s concern with the culturalistic and individualistic issues in explaining inequitable health conditions and health disparities among populations (Ahmad 1993). Critical and antiracist scholars also take a social justice approach to health that advocates for reducing social inequities which are at the root of health inequities and for creating health and social policies and economic structures that foster equitable health and quality health care for all citizens regardless of their social standings (Ponic 2007).

Antiracist scholars, such as Ahmed (1993) and Jiwani (2001) have offered important critiques of Western biomedicine as a racialized and patriarchal system of dominance. As Jiwani pointed out, Western biomedicine tends to regard and objectify a person as “a constellation of symptoms to be categorized, managed and processed” (2001, 15) and reproduce the hierarchical relations between patients and healthcare providers – relations that particularly render immigrant women of color as powerless victims. Ahmad insisted that the biomedical model of research and practice diverts attention from the production of ill health to its distribution among individuals, and perpetuates the ideology of victim blaming by relating health problems to individual lifestyles. As a result, Ahmad also argued, biomedicine “depoliticizes and individualizes ill health, treats the afflicted in isolation from their social, economic, and citizenship context and thus legitimates structural inequities and supports the status quo” (1993, 12). The biomedical approach promotes the ideologies of liberal individualism through its attempts to identify behavioural or genetic medical risk factors of ill health and to assume individuals’ responsibility for taking control of their health, and then to condemn those unable to meet their health needs as
deficient or failing (Anderson 1996; Fiske and Browne 2006). Rather than highlighting the health behaviour and lifestyle or cultural health practices of individuals within certain racialized groups, feminist antiracist health scholars (for example, Dossa 2004, 2005; Dyck 2004; Dyck and Dossa 2006; Jiwani 2006) have shifted the focus on race and gender, and studied the impacts of these socially constructed power relations and structural factors on the health of immigrant minority women.

Many critical feminist and antiracist health researchers have also used postcolonial theories in examining immigrant minority and other racialized women’s health issues (for example, Anderson 2000; Browne, Smye and Varcoe 2007; Culley 2006; Guruge and Khanlou 2004; Reimer Kirkham 2003). Feminist postcolonial theories, while retaining antiracist approach’s central focus on the issues of race and racialization, also explain how these processes intersect with gender, culture and class to structure human relationships within particular historical and neocolonial contexts (Browne, Smye and Varcoe 2007). Postcolonial analysis in the realm of women’s health, as Browne, Smye and Varcoe have noted, brings to increased attention the colonizing, racializing and neocolonial practices which continue to construct race and culture as taken-for-granted categories to locate non-European women as the essentialized, often inferior, and subordinate ‘other.’ Thus such theoretical perspectives bring to the forefront the “… socio-historical positioning, culture, race, and racialization as intersecting factors shaping the health and social status of women” (ibid., 134). Such perspectives can help understand how racialization, intersecting with other social categories including class and gender, perpetuates inequity in society and how these inequities of race, class and gender relations organize differential experiences of health and health care for ethnic minority women (Tang and Browne 2008).

Anderson (2000) asserted that postcolonial feminist perspectives provide tools for analysing how the intersecting social relations of power shape the experiences and meanings of health and illness of immigrant women of color in the diaspora, and organize their ability to manage episodes of illness. She has put forward the idea of a postcolonial feminist epistemology, grounded in the inclusion of voices from the subaltern and the recognition of their historical positioning, to construct knowledge for practice and praxis. Thus critical feminist perspectives
enriched by antiracist and postcolonial scholarship can help us understand healthcare practices within wider political, socioeconomic and historical contexts, particularly the way in which the historical and current positioning and racializing of South Asian immigrant women in Canada influence their health and access to health care. Postcolonial and antiracist feminists have critically examined the deeper and broader structural forces (colonization, gender discrimination, racial and class exploitation, poverty, globalization) that determine the health and the illness of marginalized people. Anderson (2000) further argued that research and knowledge of how globalization and healthcare reform negatively impact the health and health care of women of color and the poor must focus on gender, racialization, and health, especially on how gender and race intersect to put racialized women at a disadvantage.

**Intersectionality and Immigrant Women’s Health**

Although critical feminist antiracist and postcolonial theories provide important understandings of how structural inequities and power relations shape immigrant and racialized women’s health and healthcare experiences, the complexities of racialized women’s experiences of immigration and health inequities cannot be fully captured without considering the interlocking nature of the oppressive systems and the intersections of race, class, gender and immigration status in the lives of immigrant minority women. Interlocking oppression means gender, race and class work together or mutually construct one another and intersectionality refers to the dynamic social positions and identities of each individual and group within interlocking structures of oppression (Hill Collins 1995). The concept of intersectionality emphasizes that different dimensions of social life cannot be separated out into discrete and pure strands, and that different people experience the interconnected structures of power and inequalities differently depending on their relative positionings within the matrices of domination and privileges in particular historical, geographical and social contexts.

For immigrant women of color, Anderson (2000) correctly insisted that gender relations cannot be separated from the processes of racialization, class relations and other social relations that structure their lives, ghettoization in the low-paid sectors of the labour market, and exclusion from positions of power and privilege. Gender, race, immigration status and class intersect to put immigrant and minority women at a great disadvantage and impact their ability to manage health and well-being. Feminist researchers have opposed the traditional biomedical focus on genetic
and behavioural risk factors and disease prevention, and have increasingly located women’s health within the socioeconomic and broader contexts that affect or determine health and wellbeing. The social determinants of health, also known as health promotion and population health in Canada contrasts with the traditional focus on biomedical and behavioural risk factors and directs attention to economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole (Raphael 2004). The social determinants of health approach focuses on the quantity and quality of a variety of resources that a society makes available to its members such as, income, availability of food, housing, employment, health and social services, and such an approach views economic and social policies as more appropriate means of improving health and mitigating health inequities (ibid.). The Public Health Agency of Canada has adopted the population health framework which examines several social and economic factors that influence health behaviours and health outcomes including income, employment and working conditions, food security, environment and housing, early childhood development, education and literacy, social support systems, and access to health care (The Chief Public Health Officer’s Report on the State of Public Health in Canada 2008). The critical feminist perspectives to the social determinants of women’s health view the health differences among Canadians as resulting from social forces such as poverty, education, food security, employment, housing, racism, social exclusion and neoliberal economic restructuring (Anderson 2000, 2006; Ponic 2007).³

Raphael (2006) pointed out that the social determinants of health approach to public health, health research and public policy development continues to be secondary to traditional

³ A number of national and international texts and policy documents have advanced the population health or social determinants of health framework. For example, *Ottawa Charter for Health Promotion* (1986), *Canada Health Action: Building on the Legacy* (1997), and *WHO to Establish Commission on Social Determinants of Health* (2004) have played important roles in conceptualizing and organizing Canadian health care (Raphael 2006; Spitzer 2009). Although these primary documents are relevant and important to understanding the institutionalized barriers to South Asian women’s reproductive health and participation in cancer screening, the current research remained primarily focused on intersectionality and women’s health scholarship that helped to critically understand the intersecting nature of the social determinants of racialized immigrant women’s health including gender, race, class and immigration status. As Vissandjee, Apale and Wieringa (2009) have indicated, the immigration factor has been relatively ignored as an important health determinant in the social determinants of health literature and also in intersectionality and health literature. The impact of immigration processes on the health and healthcare experiences of the South Asian women in the current study has been elaborated in Chapter 5 and the ways in which Canadian immigration policy determine or impact women’s access to health care including cancer screening services have been discussed in Chapter 6.
medical and behavioral health paradigms. Also, much of the work lacks a “critical social science” perspective that illuminates the political, economic, and social forces that shape the quality of the health determinants (ibid.). On the other hand, intersectionality provides “a holistic, interactive, political-economic, and gendered perspective that is vital to understanding conditions of gender, migration and health” (Spitzer 2009, 139). The social determinants framework recognizes the socioeconomic discrimination and health inequities experienced by racialized women; however, the ever-expanding list of the health determinants may not recognize “the dynamic interplay between different levels of determinants” (Vissandjee and Hyman 2011, 259), or how the factors complicate and intersect with each other. While the social determinants of health approach is foundational to the intersectional analysis and understanding of racialized women’s health, the multiplicity and complexity of the determinants and the multidimensional nature of health inequality in vulnerable populations demand that we pay attention to the processes through which the complex intersections of gender, race, class, and other social relations operate in everyday interactions to determine women’s health (Anderson 2006; Kobayashi and Prus 2011). Therefore, Anderson suggested, “It is this complex interaction between racialization, gender, and class relations that we need to explore if we are to get a handle on the determinants of women’s health that are inclusive of all women who make up the Canadian mosaic” (2006, 12).

Some critical and antiracist feminists (such as Brah and Phoenix 2000; Hill Collins 1999) have argued that the seeds of intersectionality were sown in the antiracist movement during the 1800s. Their analysis of the legendary speech of Sojourner Truth with the lens of intersectionality shows how the ever-powerful question ‘Ain’t I a Woman?’ asked in the mid-nineteenth century challenged the essentialization and universalization of the category ‘woman.’ Hesse-Biberr and Yaiser (2004, 106) draw attention to the fact that feminist scholarship frequently failed to analyze the important “interrelationship” or “intersectionality” among the categories of race, class, gender, sexuality and nationality within specific historic locations leaving the experience of the ‘others’ outside the history and social processes in which they live their daily lives. On the other hand, social relations and oppression based on gender was often the central focus and while the issue of difference was acknowledged, there was still a lack of recognition of differences as being socially constructed and connected (ibid.). Intersectionality, a relatively new approach in feminist analysis, began to gain much attention and popularity in the
1990s. It attempted to examine how gender, race, class, and nation mutually construct one another rather than examining them as distinctive social hierarchies (Hill Collins 2000). Black feminist critiques (by hooks 1981; Crenshaw 2000; Hill Collins 1999 and others) provided important theoretical tools for critical inquiry into the intersection of race, gender and class in the lives of black women as well as other women of color who share the experiences of racism, capitalism and patriarchal oppression in a white male dominated society. The intersectional approach thus developed from the vantage point of the black women and other women of color, and paid attention to the multiplicity of experiences among women, and to the local or internal differences within a particular group or community. Black feminist critiques made it clear that prioritizing one aspect of oppression at the expense and exclusion of others fails to address the totality as well as multiplicity of oppression and experience, and that a synthesis of race, gender, class and sexuality through the lens of intersectionality may avoid inappropriate essentializing of women’s experiences and by so doing can provide a better understanding of the diversity, subjectivity and agency of women of color.

Hill Collins (1999, 161) has further stressed that the black feminist attention to the interlocking nature of oppression is significant because: first, it shifts the entire focus of investigation from one aimed at explicating elements of race or gender or class oppression to one whose goal is to determine what the links are among these systems; and second, it does not prioritize one form of oppression as being primary and then deal with the remaining types of oppression as additive or supportive variables within the most important system. The scholarship on the intersectionality of race, class, gender, and sexuality emphasizes these notions as social constructs, which, Weber (2004) insisted, cannot be understood outside the contexts of the real lives of real people. Weber also pointed out that macro social structural trends are often represented analytically as a set of “lifeless statistics about different populations” (129), which makes little sense about how they impact people’s lives. As she so powerfully pointed out,

[R]ace, class, gender, and sexuality are not reducible to immutable personality traits or other seemingly permanent characteristics. Instead they are social constructions that often give us power and options in some arenas while restricting our opportunities in another…we cannot argue that we are all oppressed or that our oppressions can simply be added up and ranked to identify the most oppressed group of the most victimized individuals. […] No simple mathematical relationship can capture the complexity of the interrelationships of these systems (ibid., 131).
The concepts of race, gender and sexuality are not considered in intersectionality theory as permanent and unchangeable characteristics of individuals, and rather the historical specificity and the relational as well as conflicting nature of these inequalities in real lives are appreciated. Weber argued that in order to fully grasp the nature and significance of this intersectionality, the meanings of race, class, gender and sexuality must be examined as they are embedded in the structural or macro (community and social institutions) level, and as they are expressed and experienced in social psychological or micro (everyday lives of individuals) context. Weber’s argument resonates with Brah and Phoenix’s (2004) position that draws attention to the importance of conceiving the subjective aspects of the intersectionality of race, class and gender along with its social and structural content. Brah and Phoenix contended that the intersection of race, class and gender is subjectively lived, while it is also part of social structures and involves differential or discriminatory treatment of people. It is by studying these intersections, they insisted, that a more complex and dynamic understanding of gender, race, and class can be achieved than by a focus only on social class or race. The recognition of race, social class and sexuality as they intersect and differentiate women’s experiences disrupt notions of homogeneous categories, such as ‘woman’ along with its assumptions of gender universality.

A key aspect of intersectional analysis is to unpack the important linkages among the broad structures, trends and events and the ways that people in different social locations live their lives and resist oppressive forces. Intersectional theory’s attention to the ways in which race, gender, class and sexuality operate simultaneously in every social situation help to understand that people can exist at various locations simultaneously along all the dimensions of race, gender, class and sexuality and that people define their identities accordingly. Such simultaneity indicates that we can be dominant (privileged) and/or subordinate (oppressed) at the same time. Weber (2004) was keen to note that recognition of the history of subordination as well as examination of the actions, motivations and resistance of the subordinate group can help us to comprehend the human agency, resilience, creativity and strength of oppressed group members. Such a complex analysis not only avoids easy generalization, it also demands meticulous attention to the multiple dimensions of inequality, and to particular nuances and specificity of contexts because differences are never fixed and instead always relational.
The intersectionality approach in health research, informed by critical feminist theories, centres research around the lives of multiply oppressed groups, particularly women of color and sees activism for social justice in health for all people as part of the knowledge production process. Driven by goals of equitable health, this approach attempts to identify, analyze and address the health disparities created by broader economic and political structures and social relations of power. Intersectionality and health scholarship asserts a broader conception of health, situates health in communities and families (not simply in individual bodies), and emphasizes power relationships (not just distributional differences in resources) as central to social inequities and health disparities (Weber and Parra-Medina 2003). It calls for health research that simultaneously addresses the intersections of race and ethnicity with gender, class, age and sexualities, and their impacts on women’s health (ibid.). Such research and analyses of women’s health “contextualize women in their diverse social and economic circumstances and understand gender as inseparable from other forms of social differences such as race, ethnicity, culture, class, sexual orientation, gender identity, and ability” (Varcoe, Hankivsky and Morrow 2007, 9). Mullings and Schulz (2006) pointed out that intersectionality helps to understand the complex phenomena (social relationships and dynamics) underlying health, to apprehend the ways that these relationships of power are created and maintained, and thus to understand the ways that they may be modified to reduce disparities in health. Weber and Parra-Medina (2003) also elaborated the need for an intersectional approach to understanding and eliminating disparities in health and health care. They noted that there is a rising awareness within the traditional health disparities research about the need for new approaches, such as intersectionality, to address the problem of ongoing health disparities. Many of the complexities and richness of intersectionality and health scholarship are being increasingly emphasized and called for in mainstream or traditional health disparities research and intervention (Hankivsky 2011). Yet, as Weber and Parra-Medina accurately argued, since these models are not primarily designed to explicate and challenge the social systemic processes that constitute social inequality, and since they do not emerge from the perspective and experiences of multiply oppressed communities – the simple modification of these traditional models is unlikely to significantly change our understanding of health disparities.
Antiracist and Feminist Critiques of Culture, Multiculturalism and Culturally Sensitive Care

Antiracist theories have unpacked the ways processes of racism and racialization take on new and ever-changing forms and especially how the guise of ‘culture’ perpetuates the lack of focus on systemic racism in explaining social and health inequities. Several antiracist theorists (Castagna and Dei 2000; Gilroy 1987, 1993; Razack 1994) have demonstrated the complexity, fluidity, and interconnectedness of such concepts as race, ethnicity and culture. Castagna and Dei noted that contemporary critical race studies are characterized by a shift from biologicist and assimilationist conceptualizations of race to a discussion of race in the social, historical, ideological, and political sense. The new social meanings of race inform and interpret the practice of “cultural racism,” (2000, 28) which is characterized by the re-emergence of culture in debates about races, a politicized understanding of culture, cultural production and the politics of identity. This is also about how different racisms are manifested today in definitions of citizenship, nationhood, and nationalism without an overt resort to notions of biological inferiority. Gilroy (1993) made a similar observation that prior to the consolidation of scientific racism in the nineteenth century, the term “race” was used very much in the same way the word “culture” is used today, particularly in cultural criticism. Racist arguments are made frequently by pointing not to supposed biological differences, but to cultural inferiority. In other words, differences are explained not overtly in racial terms but in the language of culture. Sherene Razack (1994) also referred to this new or “modern racism” which indicates a practice of domination encoded in the assumption of cultural or “acquired inferiority” of the ‘other’. It is also discerned, Razack insisted, by the way it is vigorously and consistently denied. The covert mechanism through which “modern racism” works has been phrased by Razack as “culturalization of racism” – within which, issues of power are subsumed under culture, and “we speak more of cultural and ethnic differences and less of race and class exploitation and oppression. […] Cultural differences are used to explain oppression; if these differences could somehow be taken into account, oppression would disappear” (897 – 898).

While Razack’s theory showed how notions of culture can be utilized to maintain and at the same time hide racism and sexism, Bannerji (2000) revealed how the state manipulates the issue of cultural differences and cultural representations in order to create and maintain people of color as ‘visible minorities’ and as the ‘other.’ Bannerji argued that non-English and non-French
people are “outsider-insiders” in Canada, situated only at the margins to the central problematic of the Canadian national identity – only as mediating factors between the fundamental conflict of the two founding nations – the English and the French (91). She argued that multicultural policy erases internal differences (for example, class and gender) and also homogenizes non-white people with a fixed ethnicized cultural/political identity. Through a process of “racialized ethnicization,” multicultural policy whitens the North Americans of European origins and blackens or darkens their ‘others’ in the same stroke (6), so that only people of non-white races are constructed as having an ethnicity. Antiracist scholars such as Bannerji (2000) and Thobani (2007) have pointed out that within the paradigm of multiculturalism, the structural, material and power differences among populations are reduced to the benign issue of cultural diversity. Ideologies of multiculturalism and diversity are also driven by the discourses of liberal individualism and equal citizenship – discourses that obscure how the processes of systemic racism and other unequal power relations construct certain peoples as the ‘other’ and restrict them from exercising their rights as equal citizens.

Culturally sensitive care, informed and shaped by the institution of biomedicine and the state multicultural policy, is a popular approach to addressing the needs of ethnic minority populations, or ‘multicultural others’ and managing diversity within the Canadian healthcare system. Several antiracist scholars (such as, Ahmad 1993; Anderson and Reimer Kirkham 1998; Culley 2006; Razack 1994; Stubbs 1993) have revealed, critiqued and opposed the ways culturally sensitive approach oftentimes results in producing stereotypic assumptions and erroneous generalizations about marginalized people while keeping the unequal relations of power unchanged. Providing culturally sensitive care involves learning about cultural groups, and this has “... in reality maintained the idea of consistent and coherent cultural groups with defined sets of beliefs and health behaviours” (Culley 2006, 150). Within the framework of culturally sensitive care women from certain ethnic communities and their culture are framed as ‘the problem’ or at best the target for change with the assumption that those cultures can be fully known and learned with effort. But such efforts frequently end up in creating and maintaining stereotypes about certain cultures.

The discourses of culturally sensitive care just as those of multiculturalism remove attention away from racism and other systemic barriers in the Canadian society while attributing
the problem of inequitable access to the culture of non-white women and maintaining their status as the ‘cultural other.’ A rejection of culturally sensitive care, however, does not disregard culture as an important health determinant. This fact is explained by Culley:

Abandoning the notion of fixed and homogenous ‘cultures’ does not mean rejecting cultural processes as one set of influences on health and health behaviours or rejecting the importance of ethnic identification in specific contexts. It rather means that we cannot ‘read off’ health status, health beliefs and behaviours from an individual’s designated ethnic status (2006, 150).

Bannerji (2000) also reminded us that it is the real social relations of power, not culture, that provide the contexts and contents for our differences and oppression. Therefore, culturalist explanations of inequitable health and healthcare access must be rejected. Bannerji’s insightful critiques of state multicultural policy unpacked how the lives and experiences of women of color as postcolonial and neoliberal subjects are socially organized along the lines of gender, race, immigrant status, and class. Such an analysis can also be useful in understanding how those experiences shape their health in the broader socioeconomic and political contexts. Culturalist views of health inequities decontextualize health and healthcare practices of women of colour from the broader political, economic, historical, and social contexts, and the existing structural inequalities of the Canadian society. For example, dominant understandings of South Asian immigrant women’s access to cancer screening services largely fail to locate their healthcare practices within the contexts of their gendered experiences of migration, relocation, and everyday racism, and racializing practices and cultures of biomedicine. But feminist antiracist and postcolonial perspectives have disrupted the notions of culture, ethnicity and community as pre-given or natural constructs, and challenged the multicultural and neoliberal approaches to health care. Antiracist perspectives deflect the attention away from the narrow focus on the individual and culture, and explicate health inequities as being produced by racialized practices that sustain structural and material inequities within and beyond the healthcare system. These perspectives can help understand how gender, culture, race and class intersect to shape South Asian women’s access to cancer screening and other healthcare services.

Some recent work in healthcare research has taken an explicitly antiracist stance and postcolonial framework to develop critical cultural perspectives. For instance, the notion of cultural safety has been used to advance a more critical understanding of “the historical, social,
and political situatedness of healthcare relations” (Anderson et al. 2003, 199). Rather than trying to understand the health beliefs and practices of different ethnocultural groups, the concept of cultural safety, Anderson et al. asserted, addresses the need to critically examine culture and health with a recognition of power imbalances and inequitable social relationships, a legacy of the postcolonial past and neocolonial present. Browne and Varcoe discussed critical cultural perspectives to understanding culture as a power relation located within a constantly shifting network of meanings enmeshed within historical, social, economic and political relationships and processes (2006, 162). They acknowledged culture as an important health determinant and recognized the importance of developing awareness about cultural diversity among health researchers and providers, but through emphasizing culture as a complex, shifting relational process, they also disrupted essentialist notions of ethnic communities as homogenized cultural groups or the ‘other.’ Such an understanding appreciates that “members of a culture are constituted through intersectional differences that go beyond culture-as-ethnic/nation/linguistic-Otherness” (Dhamoon 2004, 4). This critical perspective also views culture as co-constituted by multiple intersecting power relations and as inseparable from other social locations. As such, it shifts the essentialist focus on viewing culture as the most important or only determinant of health behaviour and health inequities to an attention on transforming the structural, political, historical and gendered relations.

Thus antiracist strategies, as suggested by Ahmad (1993), Anderson and Reimer Kirkham (1998), Culley (2006), Razack (1994), and Stubbs (1993), call for the removal of structural barriers, and for healthcare policies and public health initiatives to be framed by analyses of the complex material practices and socio-political and historical processes beyond the clinic or biomedical services. In order to ensure more equitable, effective, and accessible health care, it is not enough to ask for “cultural sensitivity” on the part of healthcare providers; structural inequities based on race, gender, class and immigration status, both inside and outside the healthcare system need to be acknowledged and addressed. Also the stereotypical and racist assumptions about minority cultures and the institutionalized culture of Western biomedicine, especially the hierarchies within the healthcare system need to be challenged. Jiwani insisted, “It is the hierarchies of power and their expression in routinized practices that require transformation if proper health care is to be accessible to all” (2006, 173). Such a change, Jiwani suggested, requires healthcare professionals to be aware of the impact of the larger structural
violence such as poverty, colonialism, and its influence on contemporary social processes. Structural changes will also involve elimination of systemic racism and the endorsement of a social justice model of health care which views health less as a commodity and more as a human right and substantive equity issue.

**Conclusion and Rationale of the Theoretical Framework**

Antiracist approach to health research advocates that the construction of knowledge about certain ethnic communities in certain political and culturalist ways (where culture is essentialized and overemphasized while hiding from view the structural and systemic barriers to health care) must be challenged. Critical feminist health scholarship suggests that strategies to promote health equity must consider the larger structural, social and political processes that produce disparities in health, and recognize the mutual interaction between race, gender, and class relationships that renders individuals and groups vulnerable to extreme injustice and suffering. The dominant strategies, guided by the ideology and policy of multiculturalism, that try to address health inequities through providing culturally sensitive care for particular marginalized groups, are neither adequate nor effective. Such approaches, as Varcoe (2008) powerfully argues, must be replaced with antiracist and social justice perspectives and strategies – strategies that address fundamental social inequities and organize and provide services in ways that take into account the inequities women experience and the impact of those inequities on women’s lives and communities. However, despite several studies that take critical feminist antiracist and postcolonial approaches and explore issues of racism, poverty, immigration experiences, and gender in the context of South Asian and other groups of immigrant women’s health, healthcare practices and policies remain largely unchanged. Vissandjée, Thurston, Apale and Nahar insisted that Canadian healthcare policies and services have failed to take an integrated approach to the needs and interests of women experiencing migration (2007, 222). Therefore, health research that explores the ways in which race, class, age, and gender relations intersect with immigration and settlement experiences to shape South Asian immigrant women’s health and healthcare experiences still seemed timely and needed, especially in the area of cancer screening. As already mentioned at the beginning of this chapter, antiracist and critical perspectives have been used by several feminist antiracist health scholars in studying many different aspects of immigrant women’s health including chronic diseases, mental health and others. But as it
appeared from the review of existing knowledge, such critical perspectives have been scantily employed in the area of cancer screening among South Asian immigrant women. Therefore, I realized that a research informed by a feminist antiracist approach to understanding South Asian immigrant women’s access to and experiences with cancer screening services within the broader political, economic, historical, and social contexts of their lives, with a special focus on these women’s diverse experiences of migration, integration and racialization in Canada would fill a major gap in the field of South Asian women’s cancer screening.

In order to avoid inappropriate essentializing about the women’s culture and to gain better understanding of their diversity, subjectivity and agency, the current study emphasized the women’s gendered and racialized experiences of migration and settlement in a new country, and the institutional, structural and socioeconomic barriers to accessing healthcare services faced by the women. The theoretical and critical approaches used in framing the current research topic and objectives, and in designing the study thus drew from feminist antiracist, postcolonial and intersectionality scholarships, particularly to understand the complex impacts of racialization and its intersection with South Asian women’s gender, age or generation, class, educational and immigration status, on their experiences of health and access to healthcare services in Canada. Such theoretical perspectives provided helpful insights about how to devise a study that could integrate South Asian immigrant women’s voices and everyday experiences to analyse and show the larger political, socioeconomic and healthcare policies, processes and discourses through which these women’s use of cancer screening services might be influenced.
CHAPTER 3: METHODOLOGY AND RESEARCH METHODS

Introduction

Ideally, a methodology is a coherent set of ideas about the philosophy, methods, and data that underlie the research process and the production of knowledge (McCall 2005). Methodology is a strategy or a course of action rather than simply a technique or method. It is the broader “… plan of action, a process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes” (Crotty 1998, 3). It includes the logic or theoretical frameworks that shape and support the selection of data sources and data generating methods as well as analysis and interpretation of that data (Crotty 1998; Harding 1987; Mason 2002). While methodology governs the research method, and guides the research design, processes and the decisions taken about how to go about generating data, particular epistemological, ontological and theoretical perspectives inform the methodology. Thus methodology should reflect the theories that support actual implementation of the methods of acquiring knowledge or data that can help address particular research questions. It should also include accounts of the whole research processes – from generation of research questions to analysis and interpretation of research data and findings.

My research aimed to explore South Asian immigrant women’s health experiences in the contexts of their everyday lives shaped by the processes of immigration and settlement, which are shaped by complex intersections of such dynamics as age, race, gender, class, religion, education and language skills, and length of stay in Canada. The research questions guided the general inquiry about how these dynamics and broader social relations, structures and processes shaped these women’s experiences with the healthcare system, especially breast and cervical cancer screening services in Canada. In seeking answers to the particular research questions I undertook a qualitative feminist research informed by a non-positivist, social constructionist epistemology and antiracist theoretical framework. I used the method of in-depth interviewing enriched by some techniques of ethnographic and collaborative interviewing processes.
Paradigms of Women’s Health Research

Ramazanoglou and Holland (2002) insist that a feminist methodology cannot be independent of the ontology, epistemology, politics and ethics, subjectivity and social locations of the researcher. Epistemological issues are not only interconnected with methodology and choice of methods for research, but as Harding (1987) argues, they also have important implications for how general theoretical structure can be applied in a particular discipline of knowledge. Crotty (1998) further notes the importance of ontology, which along with epistemology informs the theoretical perspective used to justify certain methodology employed in a research. And Ramazanoglou and Holland (2002) insist that different ontological positions offer different theoretical and political implications and accordingly suggest different strategies for knowledge production and social transformation. My theoretical frameworks shaped and were shaped by my ontological and epistemological perspectives, and were influenced by the gaps or limitations in the existing literature on South Asian women’s cancer screening, which indicated a lack of feminist antiracist perspectives to understanding the issue.

Ontological perspective refers to how one views the world as it is constituted (Crotty 1998), and includes beliefs and assumptions about the nature of some aspects of social or natural world (Ramazanoglu and Holland 2002). It is a philosophical understanding about the nature of social reality – what constitutes reality, and where and how it exists. An epistemology is the philosophy or theory of knowledge – the principles and rules by which someone decides whether and how social phenomena can be known and how knowledge can be demonstrated or represented (Mason 2002). It answers questions about who can be a knower, what is legitimate knowledge, how things can be known (Harding 1987). As Crotty (1998) puts it rather simply: “It is a way of understanding and explaining how we know what we know” (1998, 3). Guba and Lincoln (1998) further explain that epistemological position examines whether knowledge is something we accumulate objectively or something we agree upon that changes over time, and ascertains what distinguishes ‘adequate’ knowledge from ‘inadequate’ knowledge.

Feminist research is as diverse as feminist methods and epistemologies. As Hesse-Biberr and Yaiser accurately noted:
Feminism is broad in content, methodology, and epistemological positioning. Some feminists reject the scientific model of research known as “positivism,” particularly the concept “objectivity”…others assert that objective social science does have something to offer feminists and are not ready to dismiss positivism (2004, 4).

Such positivist paradigms are quite common in women’s health research, especially in traditional biomedical research. Empiricist research – both quantitative and qualitative, that emphasizes scientific or experimental evidence – has been widely applied (by men as well as women) in studying women’s health, especially in the fields of Epidemiology, Psychology and Public health. Empiricist research is concerned about issues of validity, reliability and generalizability of the findings rather than the social, historical or cultural contexts in which knowledge is produced (Murray and Chamberlain 2000). Such research generally extends the biomedical model, as Weber and Parra-Medina (2003) note, to incorporate more psychological and behavioural traits, and psycho-social characteristics among individuals and also identify the many environmental, social, psychological, behavioural and biological processes and traits that determine health outcomes.

On the other end of the continuum of women’s health research lies the critical constructionist approach that considers gender, race and class as dynamic social relations of power and explores their impacts on people’s health (Murray and Chamberlain 2000). An example of this approach is the intersectionality model of health research. Feminist scholarship on the intersectionality and health examine the multiple intersections of race, gender, class, sexuality and other systems of inequality and their impacts on women’s health (Weber and Parra-Medina 2003). Centred in humanities, social sciences and interdisciplinary studies and driven by concerns about social justice, the intersectionality approach is used in research to identify, analyze and address the health disparities created by the intricately interconnected broader economic and political structures and social relations of power and control. Intersectionality and health scholarship (Weber and Parra-Medina) underscore the importance of contextualizing women’s health in their diverse social, economic, political, cultural and historical circumstances. McCall (2005), however, argued that methodological approaches to studying intersectionality range from empirical to critical or from post-positivist to poststructuralist, while recognizing that different methodologies produce different kinds of substantive knowledge and analyses of issues and topics surrounding intersectionality. In McCall’s analyses, while some approaches examine
and explicate intersecting social inequalities often through measuring the existing or already constituted social groups, others reject those categories, and still others fall in the middle of a continuum as they acknowledge the stable and even durable relationships that social categories represent at any given point in time while at the same time maintaining a critical stance toward those categories through interrogating the boundary-making and boundary-defining processes. From the empiricist and positivist research to critical feminist and intersectional analyses and a combination or blend of these—a variety of different approaches used in studying women’s health have broadened knowledge of the complexities of women’s health issues. Overall, feminist and antiracist critiques of the reductionist approach of most biomedical research have called for more holistic understandings of women’s health within the broader social, economic, cultural, and political contexts of their lives rather than only on the interior of their bodies (Dossa 2004; Doyal 1995). The designing and analysis of my research was informed and inspired by the feminist antiracist theoretical approaches and intersectionality lens to viewing and understanding racialized women’s health as shaped by the interlocking systems of gender, race, class and immigration.

As Mason (2002) succinctly points out, different ontological positions are expressed in different theoretical perspectives about how to conceptualize social entities or realities. Different philosophical paradigms of social sciences (positivist, interpretivist, feminist, realist, ethnomethodologist, postmodernist and so on) hold that there are many different versions of the nature and essence of social things, beings and realities. These different essential components of social realities may be located in different properties or elements, such as in people, bodies, socio-cultural practices, discourses and so on. As Mason illustrates, while a certain paradigm promotes an ontological position which sees social life or reality as a collection of social discourses, another paradigm may see an individual psyche or personality constituting empirical reality. As such, women’s accounts of their lived experiences may provide important entry points to understanding their social realities. As I was trying to understand the broader social structures, processes and relations that shaped South Asian women’s experiences through in-depth interviews, I was also conforming to Mason’s position that “it is useful and possible to frame intellectual puzzles about the social world, and that these can be answered or addressed through empirical research rather than simply through abstract theorizing” (ibid., 22). Such a
perspective appears to presuppose a reality existing outside the mind or human consciousness, a main tenet of realism.

As Miles and Huberman (1994) have pointed out, realism has come to mean many things, and often been confused with objectivism. But as Crotty (1998) also pointed out, realism does not necessarily correspond to objectivism (positivism) which not only posits the existence of an objective world/reality but also views this reality to be independent from subjective reality. In realism, meanings about social and physical world are constructed though their interaction with human consciousness. Contrary to the views of objectivism, Ramazanoglu and Holland’s (2002) views maintain that knowledge of social life and world is produced in particular social, historical, political and intellectual conditions and situations. My research questions and methodologies are quite consistent with Ramazanoglu and Holland’s ontological position of ‘historical realism’ that views reality as shaped by gender, ethnicity, social, political, cultural factors that appear ‘real,’ and attempts to understand reality at any given time and context taking these factors into account (Guba and Lincoln 1998). This ontological position is also compatible with qualitative research methodology as well as feminist antiracist theories and epistemology.

While realism views the social and physical world to be constructed through the interaction between objects and human consciousness, constructionism, as an epistemology, maintains that there is no objective reality to be discovered and that meanings are attributed socially to the objects as a result of our subjective engagement with the objective/physical world. Although there are many strands of this epistemological view, as Crotty (1998) noted, one or other form of constructionism is claimed in most perspectives or paradigms other than positivist and post-positivist ones. Social constructionists do not believe in the objectivity of research findings or truth and rather believe in multiple interpretations or more than one perspective or argument about realities.

Closely connected with the epistemology of social constructionism, which believes in the interdependence of the subjective and objective worlds or realities, is my ontological position of historical realism. In fact, “Realism in ontology and constructionism in epistemology turn out to be quite compatible. This is an example of how ontological issues and epistemological issues arise together” (Crotty 1998, 11). It is also congruent with the critical feminist perspectives that
view gender along with race, class and other relations of power as socially constructed categories, and biomedicine and health as social constructions as well (Weber and Parra-Medina 2003). Constructionism as an epistemology also views all knowledge – quantitative or qualitative – alike on equal footings; all as some form of construction while maintaining the views about the impossibility of objective knowledge.

**Situating Knowledge Production**

Feminist methodology scholars, such as, Haraway (1988, 1993), Harding (2004), and Bhavnani (2004), while realizing the impossibility of attaining conventional objectivity, argued that this needs to be replaced by or transformed into “feminist objectivity,” which simply means “situated knowledge.” The main tenet of this kind of objectivity is, as Hesse-Biberr and Yaiser explained, “The nature of truth is that it is partial, situated, subjective, power imbued, and relational” (2004, 13). Harding’s “strong objectivity” examines not only the how, but also the why of a research project (Hesse-Biberr and Yaiser 2004). It is a process that obligates the researcher to disclose her/his subject positions, histories, influences, beliefs, and morals all along and at every step of the research process. Rather than taking a value neutral, detached and objective position, feminist researchers usually start from their own personal experiences (Reinharz 1992, 260) and critically situate themselves within the research process and production of knowledge. My research interest has been shaped both by my academic endeavour in a Canadian university and my personal experience as a South Asian immigrant woman from Bangladesh. The current research topic has been built on the research undertaken in my Master’s program in Women’s Studies which examined how the race, gender and class biases in Canadian immigration and related policies create negative implications and barriers for immigrant women to access state-funded services, including shelters for survivors of domestic violence and mental health care.

Despite the disagreement among feminists over the distinctive features of a feminist research, such research tends to share certain political and ethical concerns, particularly that of social change. There is a common ethical concern for “the morality of social investigation” (Ramazanoglu and Holland 2002, 3) and a commitment to political activism and social justice (Hesse-Biberr and Yaiser 2004). For Harding and Norberg, a good social research is a socially engaged one – ethically and politically accountable for its social consequences – a more
desirable way for feminists to produce knowledge that can promote the development of more democratic social relations (2005, 2010). Thus feminist researchers take responsibility for the practical and ethical implications of their decisions about knowledge production, and aim to produce knowledge that has potential to be used for effective social transformation. As a South Asian immigrant woman and as a feminist scholar, my research interest has been kindled not only by the existing gap in the literature of South Asian women’s use of Pap smear and mammogram, but also by an ethical and political commitment to social justice and more equitable and just healthcare policy and practice.

Patricia Hill Collins (1999) has argued that Black women’s and other marginalized groups’ status of “outsiders within” the white dominated academia and the mainstream sociology provide them with a unique standpoint for producing distinctive analyses and understandings of the intersection of race, class and gender in the lives of these people. Winddance Twine (2000) has also pointed out the merits of “racial matching” as a methodological tool in facilitating a better understanding of the social realities from the standpoint of the racially oppressed and addressing the absence of race analysis in mainstream white feminist discourse. My own location as a feminist of color in the white Western academia and my insider status within the South Asian community therefore, were likely to provide me with certain epistemological and methodological advantages to better understand these women’s perspectives and experiences and thus to produce reliable and convincing knowledge. As Reinharz insists, the “epistemology of insiderness” claims that being an “insider” enables a researcher to understand the experiences of a community in a way that would not be possible for an “outsider” (1992, 260).

As such, I had claimed in my research proposal that my ability to converse in a number of major South Asian languages (Bangla, Hindi, and Urdu) and familiarity with the cultural nuances and metaphors as an ‘insider’ to the community would be an asset for this project. In many cases this was proven true. As a South Asian woman I was able to attract interest, attention and trust of many women in my ethnic community. I was easily welcomed to many women’s houses and never encountered any discomfort in having conversations about women’s breast and cervical health and illnesses, and the cancer screening processes which are quite invasive into women’s interior body parts. As an immigrant woman I could share with many women my experience of financial and other struggles. My heterosexual, married background and experience of mothering
helped me to build rapport with many women. But I was unable to include in the study women of different sexual orientations. Only one of the participants was single and rest of the women were presently or previously involved in a heterosexual marital relationship.

However, I did not always feel like an insider to the community. Given my understandings of the socially constructed and fluid nature of identity, and of the mutability and artificiality of the insider/outsider dichotomy as suggested by Naples (2003), I knew that my insider status within the community would not be guaranteed at all the times. Naples (2003) provides ample examples of the multiple and fluid state of fieldwork identities for feminist ethnographers, and in depth accounts of how their insider/outsider identities are re/negotiated throughout the fieldwork period. I had realized that my status of an ‘insider’ or ‘outsider’ within South Asian community would be contingent on the social locations of the research participants and to the extent and degree they identify themselves as well as myself as bearing certain racial, ethnic, class and other dynamics of social identity. Considering my multiple social locations as a feminist researcher, middle aged, working class (given my yearly income), able-bodied, heterosexual woman, I might have been considered an ‘outsider’ to many women within the community. My multiple locations not only determined my insider/outsider position(s) in a certain context, but also shaped the power relations within the research process.

The biggest shock to my claim as an insider came from my inability to speak Punjabi, the language spoken by the majority of South Asians in my sample as well as in greater Vancouver. Although I thought my Hindi and Urdu speaking ability would give me easy access to women from India and Pakistan, I found that elderly women from Punjab, especially those with no formal schooling, could not speak Hindi at all. Two women from Punjab, Pakistan, who had never attended school, spoke only Punjabi (and no Urdu). I was surprised to find that four different languages (Hindko, Punjabi, Pushto and Urdu) were spoken within a small sample of seven Pakistani women. Relatively young and educated women could speak and/ or read and write Hindi or Urdu because these state languages are taught in schools in India and Pakistan. I felt a certain level of comfort and identification with the Pakistani women due our same religious affiliation. On the other hand, I learned a lot about Sikh culture when I visited a Sikh temple first time in my life for the sake of this research. I felt both strange and welcomed within the Sikh community.
In the case of the Bangladeshi community I was not able to reach women beyond my own educational level and/or social status. Although my economic status was lower compared to almost all the Bangladeshi participants I felt a middle class comfort within the community due to my academic status. But I failed to attract Bangladeshi women with lower educational or English skills among whom I was probably not viewed as trustworthy or an insider. Contrarily, I might have been perceived as too much of an insider (too close for comfort) by some community members who would rather feel safer with the distance between themselves and a non-Bangladeshi researcher. I sensed a lack of trust or discomfort among some South Asian women who had reservation about disclosing their yearly income. One woman, who interpreted my conversation with her mother-in-law and her elderly neighbours, refused to ask them questions on my behalf about their socioeconomic status as she thought they would not understand or be able to answer my question. These women could not read or write in their own language, and I did not anticipate such problems before starting the field research.

In summary, certain advantages as well as disadvantages emerged from the fluid and contested nature of my insider/outsider status. Winddance Twine (2000) however, cautioned that racial matching, particularly singular emphasis on race, can result in homogenizing the experiences of a particular racial group and overlooking the intersectionality of people’s oppression due to their multiple locations or identities. As an ‘insider’ to the South Asian community, I might have also missed certain issues that would be more visible to ‘outsiders.’ Instead of claiming the knowledge produced through my research as universal, complete and ultimate truth about the experiences of South Asian immigrant women in Canada, I rather acknowledge that the product of my research is incomplete, partial and located within the relationships established through the insider/outsider boundaries during the research process. The challenges I faced in terms of interviewing and effectively communicating with the women, especially the language barriers and my feelings of being an outsider to the community clearly suggest that South Asians, like any other community, are diverse despite their commonalities of ethnic background.

**Research Design and Procedure**

Equity and justice in health care can be achieved through integrating the voices and perspectives of South Asian women as equally rightful citizens into relevant policymaking. With this
objective in mind, my research attempted to understand and incorporate the lived experiences and voices of South Asian women in greater Vancouver. Therefore, I designed a qualitative study in order to situate South Asian women’s health experiences in the contexts of their everyday lives shaped by their immigration, relocation and settlement processes. Social constructionism, one of the philosophical or epistemological foundations of qualitative research, acknowledges and highlights the active engagement of researchers in creating knowledge within certain socio-cultural and historical contexts. It also dismisses the idea of knowledge being apolitical or neutral. As such, it is a particularly compelling philosophical framework for critical feminist qualitative researchers (Morrow and Hankivsky 2007).

Quantitative methods, Ramazanoglu and Holland argued, “offer limited access to accounts of experiences, nuances of meaning, the nature of social relationships, and their shifts and contradictions” (2002, 155). Qualitative methods, on the other hand, are supposed to challenge and transform the status quo by providing insights of women’s lives from their own perspectives, and access to women’s own interpretations of gender relations and to women’s voices, especially through in-depth interviews and participatory action research (Hankivsky et al. 2005; Lawson 1995; Reinharz 1993). Guba and Lincoln (1998) observed that feminists and critical theorists predominantly use qualitative methodology with a goal to critique, transform and emancipate. Although policy makers most often tend to favour research findings of quantitative studies involving large samples, Mulvihill and her colleagues (2001) accurately noted that quantitative methods often fail to capture the unique and gendered experiences of marginalized women, and that there is a particular need for more qualitative research with respect to the differential or unique healthcare experiences of immigrant and refugee women from non-European cultures. In the health context, qualitative research provides rich and detailed descriptions about how people experience health and illness within the broader contexts of their lives (Morrow and Hankivsky 2007), and gives insights about the agency and voices of people seeking health care, particularly the less privileged groups (Segal and Vasilikie 2003). Therefore, while developing a methodological approach to answering my research questions I found feminist qualitative research informed by the social constructionist epistemology as a possible good fit and it was also consistent with my ontological and theoretical frameworks.
Data Sources

In-depth interviews, audio-recorded and conducted in individual, couple and group contexts, constituted the main source of data. Two of the individual interviews were not audio taped and rather recorded in written notes due to technical difficulties in one case and reservation of the participant in another. Additionally, participants were asked to provide their personal and demographic information on a separate checklist. Information gathered through personal/demographic data sheets and field notes about the interview processes comprised valuable data for qualitative analysis. My field notes, written after finishing the interviews, provided situational or contextual information particularly about participants’ class or socioeconomic conditions, everyday life contexts, lifestyles and life constraints among others. I tried to take notes, especially at the beginning of the interview, but found it distracting for staying focused on the conversation. As such, I did not take many notes during the interview unless necessary, and rather wrote my reflexive reports after coming home. The notes also included my reflections of the interviewing process and insights about the interview relationships, or any other noticeable events, cultural aspects, non-verbal communication and the context of interviews, and often even early analyses of the interviews. These additional sources enhanced the data quality and helped me better contextualize the women’s voices and experiences, and analyse those at a greater depth or breadth. They were also useful for reflexive reporting. In total, 31 women were interviewed in individual, couple and group interview.

For example, a few interviews were done in the presence of children even though childcare was often paid. In one case, the father was babysitting in a room next to the living room where the interview was going on. But the children were very young and the older one often visited the mother while the younger one had to be nursed in the midst of the interview. This reflected the gendered role of mothering young children and lack of childcare skills on part of the father. The children had a professional babysitter but the service was not available on weekends, which was more appropriate for the interview. This is a social reality of many new immigrants with young children who lack the support of extended family members. In another case in an extended family scenario, the toddler granddaughter frequently sneaked into the living room even though the mother and grandfather were present inside the house. This indicated the affinity of the child to her grandmother and the important role she played in caring for her grandchild (who was not attending any daycare on a week day), and also the fact that it takes the whole family and often the community to take care of a single toddler. On a different occasion of a couple-interview, the young mother of two young children was helping with interpretation of my conversation with her mother-in-law and an elderly neighbour. The children had to stay in the living room with the TV on because their father was sleeping inside on a weekend morning after his graveyard shift. My own experience of raising young children in Canada in absence of extended family support helped me to be sensitive to the realities of the participants’ lives but I realized while transcribing that the presence of young children during the interview often severely impacted the audio quality.
settings. The total number of women under the individual, couple and group interviews are shown in Table 3.1.

Table 3.1: Number and Types of Interviews

<table>
<thead>
<tr>
<th>Types of interviews</th>
<th>Number of interviews</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Couple</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Group</td>
<td>3</td>
<td>13 [6,4,3]</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>31</td>
</tr>
</tbody>
</table>

My initial research plan included individual in-depth interview as the only method of data collection. But as Mason (2002) points out, qualitative research is characteristically exploratory, fluid, data-driven and context-sensitive. Flexibility and sequential nature of research design are important features of qualitative research. As the research progressed, and as I increasingly depended on snowball technique for finding research participants, some women showed interest in being interviewed with a friend or neighbour. In addition to facilitating women’s preference, this option provided an advantage in addressing the language barriers in interviewing. A large number of the participants were from Punjab (India) and spoke only Punjabi. A couple of women from Pakistan also spoke only Punjabi. And often one of the women in a couple or group setting spoke good English and could help us (the other participant[s] and I) with the translation. Furthermore, being outnumbered by the participants in the couple or group setting might have downplayed my power as an academic researcher and offered women a less intimidating and more comfortable atmosphere. Feminist interviewers have noticed that conversation in a group setting holds a potential of generating new, complex and rich details about women’s experiences because the data come from the participants’ interactions with each other (Morgan 1996). The group interview format “facilitates women building on each other’s ideas and augments the identification of patterns though their shared experience” (Callahan 1983, 38, cited in Reinharz

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5 This was the case in two group and one couple interviews. In an individual interview situation, a family member (daughter) helped with the interpretation. In a couple interview a daughter-in-law mediated my conversation with her mother-in-law and her neighbour. And for the group interview with women receiving facilities from an immigrant women’s family support services agency, the South Asian support worker provided assistance with translation.
Such interactions and group dynamics may invoke discussions about particular aspects of women’s lives beyond researcher’s expectations or assumptions, leading to important insights and directions for a qualitative research and analysis. In fact, women’s conversations in couple and group settings provided opportunities for instant comparisons and analysis of the similarities and differences between women’s experiences and added richness and depth to the data. This also often helped to identify and address data gaps and take new directions or make necessary changes in the research design or sampling techniques in order to enrich the data.

From methodological perspectives, the individual and group interview data seemed ontologically consistent due to their similar and complementary assumptions about the nature of social entities recognized through women’s subjective experience. From epistemological point of view, interviews in couple and group settings made it possible to include the voices of women disadvantaged by their limitation in English language and generally excluded from mainstream health research. Marshall and While (1994) pointed out that participants with significant English language difficulties have been traditionally excluded from research studies due to the language barriers.

The group interviews consisted of three to six women. When an immigrant women’s family support services agency was contacted for help with recruitment of research participants, the South Asian support worker informed that her clients requested that they be offered the option of a group interview. She proposed the idea of conducting a group interview with the women during one of their regular support group sessions, and also offered assistance with interpretation as some of the women spoke very little English or Hindi or spoke only Punjabi. The two other groups emerged as a result of the snowball technique used for finding participants. Unlike a focus group, which is usually constituted of fewer than 12 people established by the researcher for a one-time as well as time-limited discussion of a topic or issues (Reinharz 1992, 222), the women in the group interviews were either part of a support group or already knew each other and they decided to sit as a group. None of the groups was constituted by the researcher. Hence this should be called a group interview rather than a focus group. However, given the risk of compromised confidentiality in a couple or group interview, a new consent form was composed acknowledging that only limited confidentiality can be guaranteed in a group setting as what other participants do with the information discussed in group cannot be controlled by the researcher. While the research project had already been granted ethical approval by the
UBC Behavioural Research Ethics Board before the onset of data collection, further amendments were proposed to and approved by the board to incorporate the changes in interview protocol.

Women were assured that if any of them did not wish to participate in a group interview she would still be eligible to participate in an individual interview, or not to participate at all. The women were informed that the interview was not related to the support group activities in any other way. However, most of them mentioned with appreciation at the end of the interview that they benefited from this exchange of information and stories, and even said that the remuneration was not necessary at all. Women in the groups were asked the same questions asked in individual or couple setting. They were also verbally requested to keep each other’s information confidential. Despite a number of benefits, the group interview setting creates certain disadvantages, which must be acknowledged. For example, in a large group some women may dominate over the shy or quiet ones, and the time allocated in a one-on-one interview is usually divided among numerous participants. I encountered this problem in the first group constituted of six women, while I had a better control over such issues in the other smaller groups. Women who could speak English often dominated in couple and group interviews compared to women without the language skills.

Method of Data Collection: In-depth Interviewing

Methods are specific techniques and procedures for gathering or rather generating data/evidence. In-depth interviewing is a widely used qualitative research method. Feminist in-depth interviewing especially recognizes the interactive nature of the researcher-respondent relationship (Oakley 1981). Unlike mainstream interviewers, feminists usually try to establish a subjective relationship rather than an “objective” or distant one with their interviewees. In other words, feminist interviews are guided by the “feminist ethic of commitment and egalitarianism in contrast with the scientific ethic of detachment and role differentiation between researcher and subject” (Reinharz 1992, 27). Fontana and Frey (2003) illustrate the in-depth interview as an active and emergent process and negotiated text, the meaning of which is accomplished at the

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6 In general group interviews were a bit longer (average 1.5 hours) than individual (range 35 minutes to 1.5 hours) or couple interviews (average 1.25 hours).
intersection of the interactions between interviewer and interviewee, and shaped by the contexts and situations in which it takes place. Thus feminists, especially those influenced by social constructionist views, not only recognize research participants as subjective beings with agency (rather than just informant/object of study), but take into account how the researcher’s subjectivity and power relations between researcher and participants stemming from their differential social locations shape the production, analysis and interpretations of the interview scripts.

I used feminist in-depth interviewing method enriched by some techniques of ethnographic and collaborative interviewing processes. As Sherman (2001) succinctly points out the purpose and usefulness of ethnographic interviewing: it helps gather rich, detailed data directly from participants in the social worlds under study with a recognition of the complexity of human experience. And it is often governed by an interest to make the research results relevant and useful to those studied. Feminist scholars, Sherman also notes, view ethnographic interviewing as a ‘conversation’, and as such, many of them focus on the talk going on in interviews and how it is shaped by both parties. Mutual exchange and dialogue instead of interrogation are also at the heart of the collaborative process of interviewing (Ellis and Berger, 2003). Such interview attempts to close the hierarchical power gap between the researcher and respondent as much as possible. When this collaborative interviewing, mostly used for the purpose of generating stories in narrative analyses, is successful, Ellis and Berger writes, “the respondents become narrators who improvise stories in response to questions, probes, and personal stories of the interviewers” (2003, 160). Ethnographic interview data are usually generated through multiple and prolonged interviews often in the contexts of emerging or long term respectful relationships between the interviewer and interviewee. As such, Sherman insists, interviewing projects based on single short interviews would not constitute ethnographic interviewing. Although I did neither an ethnography nor a collaborative narrative, I tried to follow the conversational and collaborative techniques and styles of interviewing. I did not want to collect just information from the women but tried to encourage them to tell their stories and accounts of their personal experiences, which often involved sharing my own experience, especially of migration and health/care issues, such as pregnancy and child birth.
The interview was designed with semi-structured and mostly open-ended questions for generating ideas and understandings of South Asian women’s social reality in their own words and from their own perspectives. Interview questions were developed under three broad themes or domains of immigration, health and healthcare experiences and use or lack of use of Pap smear, mammogram, clinical breast exam and breast self-exam. While all of the women were asked questions from all three domains they were not always asked in the same order or with the same emphasis. In other words, the course and focus of the interview varied according to the particular interests and contexts of participants’ lives. For example, most new immigrants had a lot to say about their immigration experiences and settlement challenges whereas long-timers did not always provide detailed stories on those topics. This flexibility and open-endedness, an important aspect of feminist ethnographic interviewing, was useful for me to address as well as capture the diverse experiences and social realities of the women.

Feminist researchers try to avoid harm and exploitation of the research participants generally by building trust and empathy through identification or self-disclosure and development of bond, rapport or intimacy. My South Asian ethnicity and cultural orientation, personal experience of immigration, parenting and family backgrounds, my fluency in Bangla, and some degree of Hindi and Urdu speaking ability were helpful for building rapport and gaining trust of the participants. I almost always sat on the floor close to a centre table (most of the interviews were done in the living room in the women’s house) where I put the audio recorder, as this was convenient for me. I think it also helped to downplay my power as the researcher. I always addressed the elderly women as aunty and greeted them with due respect. This helped me to introduce myself as a cultural insider. It is customary in South Asian countries not to call older people by their name. I called younger women and those closer to my age by their names. All the Bangladesh women were little older than me and already known to me; I called them either sister (apa or didi) or sister-in-law (bhabi). Although people over the age of 65 are officially defined as elderly or senior citizens in Canada, some of the women referred as elderly in this study were actually under-65 years old. These women were grandmothers and considered as buzurg or respected elderly people in their families and communities and thus reflected a different generation and relation rather than simply a particular age.
In all cases interviews were conducted at a place of the participant’s choosing. The first group interview took place in the regular meeting room of a non-profit organization providing family support services to immigrant women. Contrary to my expectations, it was a nice, cozy, almost like a family room with a couple of sofas, reclining chairs and a few armchairs and this provided a rather informal and comfortable setting for the interview. We sat in a circle and again, I sat on the carpet with my recorder on the center table. One individual interview was carried out in a quiet meeting room at the UBC School of Nursing. A young South Asian professional woman was interviewed in the kitchen of a community centre. After we met each other at that centre the woman took the lead to find a quiet place there and I followed her. She claimed that she was not “quiet and shy like average South Asian woman” and I definitely felt less powerful in relation to her. Two interviews happened at my home. In one case the woman, a highly educated recent immigrant, felt that she could not accommodate or host me in her very small basement unit. On the other hand, I was quite happy to entertain her along with her family on a weekend at my home as she had previously helped me by translating the call for participants and consent form in a major South Asian language. From the beginning we felt a bonding and eventually became good friends. And in the second case, I met a very loving elderly woman who lived far-off but worked close to my home. Although I had booked the School of Nursing interview room, I decided to bring her to my home on the interview day because of her friendly and caring attitude. She brought treats for my children and I was also invited with my family to have dinner at her place.

However, although some women seemed to have opened up their hearts and shared their experiences, stories and opinions quite frankly, others seemed to be more reserved and cautious in expressing themselves. Yet there were some women who seemed to be rather quiet or shy and gave as simple or brief answers as yes or no, and even sometimes only nodded. In other words, while some women were telling their stories in their own voices, some were merely answering my questions and in those situations the interview felt like an interrogation rather than a collaborative process. Thus the quality of the conversation was impacted by women’s different personalities, special knack or facility in storytelling, and probably, different levels of trust and comfort provided by my personality and social locations, quite often at our first face-to-face encounter. Moreover, occasionally there was a language barrier. Some of the interviews were conducted completely in English or Bangla, (according to the participant’s choice) and others in
Hindi, Urdu or Punjabi mixed with English, mostly facilitated by an interpreter who was either a fellow participant or a family member. For the first group interview, a South Asian support worker provided assistance with the translation/interpretation. Although having family members or friends who were not professional or trained to interpret interview conversations had some limitations, it was the only possible alternative available in the current research context. On the other hand, as Marshall and While (1994) cited lack of enthusiasm and self-confidence as a major challenge faced by nurse researchers interviewing subjects with English as Second Language, the presence of family members and friends or neighbours might have offered trust and confidence to women lacking English skills in the current study.

**Sampling and Procedure**

Qualitative research is about depth, context and process rather than quantity. Therefore, the purposive sampling method was used to include in the research a small but heterogeneous and diverse group of South Asian women who had some common experiences. Attempts were made to include South Asian women with diverse backgrounds in order to capture the internal differences within the community and to understand how their varied experiences are shaped and complicated by such differences. It was hoped that this would help develop a deeper understanding of the intersections of race, gender and culture with other dynamic social and immigration processes, while resisting the homogenization of the South Asian community. The diverse criteria of inclusion incorporated religion, educational background and English language skill, country of origin, length of stay in Canada, language spoken, socioeconomic, employment and class status, marital status and age.

In order to include diverse women, advertisement messages and consent forms were translated in three different South Asian languages (Bangla, Hindi and Urdu). A number of community organizations serving South Asian immigrant women were contacted asking for help in connecting with their clients. The Multicultural Helping House Society in Vancouver, and the Vancouver & Lower Mainland Multicultural Family Support Services Society in Burnaby responded to my initial email contact and offered assistance. These organizations were asked to publicize the call for participants by email or by word of mouth among their clients. Agency staff members were given fliers to hand out to clients and to post on bulletin boards in common
spaces. They were also requested to provide the researcher with contact information of interested clients who would give permission to release their contacts after receiving information about the study from the community service providers. Furthermore, advertisements were posted in public places such as, a community center, a South Asian grocery store, a mosque and a Sikh temple, especially to reach women who do not use formal services. The advertisement asked interested South Asian women to contact the researcher via phone or email. Additionally, snowball technique was used to get in touch with participants. This process was congruent with the third party recruitment process, which means that participants were not asked for the contact information of other potential participants and instead were asked to spread the word about the study and provide potential subjects with the researcher’s contact information.

A typical approach to purposive sampling is the use of theoretical sampling technique. In qualitative research with in-depth interviewing technique, as Cuadraz and Uttal (1999, 162) illustrated, the criteria for selecting who to interview may change throughout the research on the basis of simultaneous ongoing collection and preliminary analysis of data that shapes an emerging theory. This means the criteria for defining the sample may change based on preliminary analyses of data as it is collected. Thus in theoretical sampling, the criteria used in the first stages of sampling are not necessarily the same as those used in the final stages of sampling because sampling is not completely defined or rather is loosely defined prior to the beginning of data collection, nor are the criteria for sampling fixed. My sampling design was similarly emergent and inductive. Initially, any woman over 18, who self identified as a South Asian immigrant and showed interest to participate in the study was included. When I had already found enough women who were using the cancer screening services, I stopped including such women and particularly looked for women who were not using the services. Likewise, when I had sufficient number of women with similar backgrounds (such as, speaking same language or same religion) I particularly targeted women with different traits through advertising in specific locations or sub-communities in particular languages.

7 In total, nine women were contacted via community service agency staff. Only one woman responded to the advertisement message posted in a community center. A few women were contacted through personal connections while the majority of the participants were recruited through snowball method.
Thirty-one women who signed in the consent form confirming their volunteer participation were included in the sample and interviewed for the present study. The interviews took place throughout a year between October 2008 and October 2009. Four women (three from Pakistan and one from India) refused to participate after the initial contact, while I declined a few women who were interested to participate because I was no longer including those who were using the cancer screening services. However, I had informal conversations with some acquaintances, who, I came to know, were using both services and showed somewhat similar patterns found among the users of the services. For example, in one situation, when I asked a Pakistani woman, after finishing the interview with her, to spread the word about my research to her friends, she said she could definitely contact more women for the study. She immediately and enthusiastically left the house to talk to her neighbours and to my amazement, gathered four elderly Punjabi women within 10/15 minutes! At that point I was only looking for non-users of the cancer screening services and I found that only one woman met that criterion whereas another woman was not sure about the use of mammogram and seemed to have confused it with simple chest x-ray. As the UBC ethics guidelines require that women be allowed at least 24 hours to decide before signing on the consent form I told them that I would come back for that one woman. Neither was I mentally ready (especially in terms of time) for doing any additional interview that day. But both the host and the potential participant insisted that I do the interview right away because they did not have any problem at all. So I decided to do another interview then and there because I felt I would have hurt their feelings otherwise. It was the most welcoming of all the interview scenarios and I could not refuse their offer for tea either. During the little tea/chai party with delicious snacks before the second interview, I had an opportunity to informally enquire about the health of the elderly women sitting there, and I came to know that although the two other women did mammograms, none did a Pap smear. When the formal interview started the other neighbours were still sitting there and chatting with each other and the interviewee did not object to it. This was almost like a group interview where the women interacted with each other and shared or compared their experiences although officially only one woman was interviewed and her experience was in focus.

The South Asian support worker, while facilitating the interpretation during the first group interview, also shared her personal experience and valuable insights about South Asian women’s experiences with the Canadian healthcare system. I received her verbal permission to
use those as data as well. One woman, who was interpreting conversations on behalf of her mother, compared between the situations of the mother (non-user of the service) and her mother-in-law (user). As a South Asian immigrant I occasionally shared my personal experience with the participants which I believe enriched the quality of data. In other words, the voices and experiences of 31 participants were bolstered by the experiences of a few other women (including myself) who were indirectly or remotely involved in the interview process. In all cases, the participants and I (the researcher) dialogued and negotiated to co-construct the data. But in some cases where an interpreter was involved, the interpreter also shaped the construction of data.

The majority of the women in the sample were from Punjab, India, which is reflective of the number of Punjabi population among South Asians in greater Vancouver. Participants’ diverse country of origin, length of stay, age distribution, educational status and yearly family income are shown in Table 3.2. The woman from Kenya was born in India, but she had migrated to Kenya with her parents at her infancy and she identified herself as a South Asian Kenyan and Kenya as her home where her parents were still living. One of the participants was born in Canada and identified herself as a ‘South Asian Canadian,’ an identification also shared by a number of participants who had immigrated to Canada from South Asia. The recruitment message asked for interested South Asian immigrant women to participate in the current study and to share their health experiences in Canada. It was open to anyone who would self-identify herself as a South Asian immigrant woman irrespective of country of birth, generation or age (except the minimum age requirement of 18 years).\(^8\) One woman referred by a community

\(^8\)In the official or legal discourse, the term ‘immigrant’ is used equivalently with ‘permanent residents,’ who enter Canada under certain immigration category, have legal status to enjoy all the rights and privileges to education, employment and health care, except to vote and carry a Canadian passport. But the popular or common sense version of the term usually refers to non-white or visible minority people, regardless of their citizenship status or place of birth, so that even second or third generation of people of Asian, African or other non-European origin in Canada are often considered ‘immigrants,’ while foreign-born white people generally are not so regarded. Peter Li (2003) has argued that the notion of ‘immigrants’ is socially constructed and that this social construction represents the ideological preferences, conceptual biases, values, beliefs and concerns of ‘longtime Canadians’ more than the actual characteristics of immigrants. Ng (1996) has defined the term ‘immigrant women’ as referring to a socioeconomic and political process whereby only certain racial or ethnic groups of women are labeled as ‘immigrants’: those who are from the third world or are members of a visible minority group, who do not speak English or speak English with an accent, and who do certain types of low-paid work at the lower end of the job hierarchy. Thus ‘immigrant women’ is a racialized category because the term ‘immigrant’
worker in an immigrant services agency decided not to participate because she thought her experiences would be very different from ‘immigrant’ women as she came to Canada at her early childhood. This woman was a member of a support group for South Asian women who had experienced family or domestic violence. On the other hand, Salina, also a member of the same support group, was born in Canada, but identified herself as ‘South Asian’ and wanted to participate in the group interview.

As Table 3.2 shows, there was a good mix of highly educated to less educated women and women with no formal literacy in the sample. Women with no formal schooling were all Punjabi speaking (4 from India and 2 from Pakistan). About 75% of all women were over the age of 40 while 26% were under-40, ranging from 31 to 76. Although in BC, the recommended age to start mammogram screening is age 40, women aged below 40 were included not only for the sake of diversity but also because Pap-smear is recommended for every sexually active woman starting from age 21. The majority of the women were long-time residents who had lived in Canada for at least seven years while nine were recent immigrants.  

is applied differently to different racial groups, and it bears different socioeconomic implications for different groups of people. Therefore, while being a ‘South Asian immigrant woman’ was a necessary inclusion criterion for my research, the meaning of this socially constructed category was not limited to its legal definition.

9 Statistics Canada usually defines new/recent immigrants as people who have been living in the country for five years or less since immigration to Canada. For example, in order to study how new immigrants adjust to life in Canada over time, the Longitudinal Survey of Immigrants to Canada (LSIC, 2001 – 2005) was designed to examine the first four years of settlement – a time when newcomers establish economic, social and cultural ties to Canadian society (Statistics Canada 2007). As the current research data indicated, the number of years required for socioeconomic integration for new immigrants may depend on a range of intersecting issues which will be discussed in the next chapters. However, in the present study, women who had lived seven years or longer in Canada seemed to be more or less financially established and mentally settled. During the interviews most new immigrants were more interested to talk about their migration experiences and current challenges of their socioeconomic integration in Canada, whereas most sponsored elderly women who had also lived in Canada for a longer time, did not particularly talk about challenges of immigration and settlement. While all the long-timers called themselves South Asian Canadian or Indo-Canadian or simply Canadian citizen most recent arrivals called themselves South Asian immigrants. This indicates new immigrants’ lack of perception of themselves as well-established or well-integrated into Canadian society.
### Table 3.2: Demographic Characteristics of the Participants

<table>
<thead>
<tr>
<th>Demography</th>
<th>Number of women (N = 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Country of origin</strong></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>15</td>
</tr>
<tr>
<td>Pakistan</td>
<td>7</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>5</td>
</tr>
<tr>
<td>Fiji</td>
<td>1</td>
</tr>
<tr>
<td>Kenya</td>
<td>1</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>1</td>
</tr>
<tr>
<td>Canada</td>
<td>1</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>30 – 40</td>
<td>8</td>
</tr>
<tr>
<td>40 – 60</td>
<td>15</td>
</tr>
<tr>
<td>60 – 80</td>
<td>8</td>
</tr>
<tr>
<td><strong>Level of education</strong></td>
<td></td>
</tr>
<tr>
<td>Graduate</td>
<td>8</td>
</tr>
<tr>
<td>Professional</td>
<td>4</td>
</tr>
<tr>
<td>Diploma</td>
<td>3</td>
</tr>
<tr>
<td>Secondary</td>
<td>9</td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>No schooling</td>
<td>6</td>
</tr>
<tr>
<td><strong>Length of stay in Canada</strong></td>
<td></td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>9</td>
</tr>
<tr>
<td>7 – 10 years</td>
<td>6</td>
</tr>
<tr>
<td>12 – 20 years</td>
<td>10</td>
</tr>
<tr>
<td>More than 20 years</td>
<td>5</td>
</tr>
<tr>
<td><strong>Yearly family income (in Canadian dollars)</strong></td>
<td></td>
</tr>
<tr>
<td>Below 10,000</td>
<td>7</td>
</tr>
<tr>
<td>10,000 – 15,000</td>
<td>9</td>
</tr>
<tr>
<td>20,000 – 35,000</td>
<td>4</td>
</tr>
<tr>
<td>50,000 – 70,000</td>
<td>5</td>
</tr>
<tr>
<td>Above 100,000</td>
<td>2</td>
</tr>
<tr>
<td>Not reported</td>
<td>4</td>
</tr>
<tr>
<td><strong>Occupational status</strong></td>
<td></td>
</tr>
<tr>
<td>Self employed</td>
<td>2</td>
</tr>
<tr>
<td>Looking for job</td>
<td>4</td>
</tr>
<tr>
<td>Academic job</td>
<td>1</td>
</tr>
<tr>
<td>Part time service job</td>
<td>2</td>
</tr>
<tr>
<td>Full time semi-professional job</td>
<td>2</td>
</tr>
<tr>
<td>Seasonal farm work</td>
<td>1</td>
</tr>
<tr>
<td>Retired from seasonal farm work</td>
<td>3</td>
</tr>
<tr>
<td>Early retirement in home country</td>
<td>2</td>
</tr>
<tr>
<td>On disability benefit</td>
<td>7</td>
</tr>
<tr>
<td>Stay home/housewives</td>
<td>7</td>
</tr>
</tbody>
</table>

*One woman was born in Canada.

Although a large number of the women were either housewives or on disability benefits due to chronic health problems, many women were engaged in paid employment ranging from seasonal farm work or part time service job to full time self-employment and academic job. A
number of women who were recent immigrants were looking for a job at the time of interviews – all had a professional degree and had not found a job yet that matched their qualifications. Two of the housewives mentioned having some home based income-earning activities such as sewing. The majority of the women (16 out of 27) had a yearly family income of $7,000 – 15,000. Most of the women under these income categories were either on pension or on disability benefits. Four women refused to report their income and the same women also opted not to identify their class position. Although 16 women in total reported their yearly income to be less than 15,000 only five women identified themselves as poor and a couple of them as lower middle class. Most of the women in the sample were married with an exception of one single and one widowed woman. Some of them (total 8) were either divorced or separated. All of them were in heterosexual relationships and all the married women except one had children. The majority of the women were Sikh while 13 were Muslim and one Buddhist.

In addition to answering to questions about their yearly income, educational, employment and housing status, women were asked to self-identify their socioeconomic status or class position. Interestingly, many women, while self-identifying their socioeconomic status, did not simply reflect their income level and rather based their assessments on other criteria, such as, status before immigrating, level of education and/or standard of living. One woman, assessing her class position, said, “I think I can say upper middle class. Yes, we have nice house, nice car, nice clothes and jewelries – everything one needs for a good life, and we have it all!” On the other hand, some women mainly considered their earnings to assign themselves under poor or working class categories. The first eight participants were not asked to self-identify their socioeconomic standings because by the time I came up with the idea of asking women for self-assessment due to the complexity of labelling women with a class status based on few Socioeconomic Status (SES) criteria, eight women had already been interviewed. However, based on some SES criteria (income, housing, job and educational status) I assumed five women belonged to the middle, two to the upper-middle and one to the lower middle/poor class. I admit that this might not echo all these women’s self-assessment because I was quite surprised a couple of times listening to the women’s self-evaluation of their class status. For example, one recent immigrant living in a one-bedroom basement suit, struggling to find a job that would fit with her qualifications, said, “My living standard hasn’t changed much [from that before immigration]. I
have good education, a clean place to live and everything that I need… the public transportation system is so good here that I don’t really need a car. So I think I still am a middle class woman.”

Some other gaps and limitations in the research design and procedure must be acknowledged in this connection. Unfortunately, there was only one woman from Sri Lanka, Fiji and Kenya each in the sample, and no woman from Nepal or Bhutan and other East African countries that source immigrant women of South Asian origin in Canada. Very few women responded to the advertisement message, which was written in black and white prints and was not very eye-catching. The message was probably not very appealing and might have scared away some women as I mentioned the research topic as cancer and cancer screening instead of ‘health’ which would have been more positive as well as inclusive. Additionally, a lot of elderly women from India and Pakistan cannot read or write in their own language and therefore it was not possible to reach them via any written message anyway. Overall, the snowball technique was more effective than other sampling approaches. Despite my own membership in the Bangladeshi community I was able to include the least number of women (all middle aged and no elderly) from that community. The Bangladeshi community in Vancouver is much smaller and newer compared to the Punjabi or Pakistani ones and the population is also much younger. In other words, there are fewer women aged 60 and over in the Bangladeshi community. I contacted a community organization named Elderly peoples’ ( Probeen) Wellness Society established by and for 40 years and older men and women from Bangladesh in order to get in touch with older adult women in the community. An email with the Bangla version of the advertisement was circulated among the members but in vain. Initially I failed to realize that my Hindi and Urdu speaking ability would not ensure access to women who only speak Punjabi. Little did I know or anticipate that elderly women from Punjab, especially those with no schooling do not know how to speak Hindi, the state language of India. Given my inability to speak Punjabi I did not try to advertise in Punjabi at the beginning. Later on a friend volunteered to translate the advertisement message into Punjabi which was posted in a Sikh temple but elicited no response. Overall it was much harder to locate women who were not using cancer screening than women who were using the services.

There were also other barriers to ensuring participation of many women, especially the elderly from the South Asian community. For example, I noticed a fear of government vigilance
and fear of signing on any paper especially among elderly Punjabi women who had limited literacy and little or no formal schooling. One elderly woman had her husband read the consent form and obtained his approval before signing the consent form. Those who were working full time in paid jobs on top of performing their parenting duties had severe time constraints. It was often hard to match a time for interview with the participant due to my own parenting responsibility as well as personal limitations, such as lack of driving skill. One woman feared being audio-taped and I took written notes of our conversations. Such fears along with time constraints might have prevented some other women from responding to the call for participation even though confidentiality and anonymity were promised.

**Ethical Considerations**

Feminist researchers are concerned not only with ontological and epistemological positions but also the ethical implications in designing, implementing, and reporting a research project. A feminist ethical framework is one of the distinguishing features of feminist research wherein the well-being of the participants is an ethical priority, to which the needs of the researchers, their institutions and profession, must be subordinated (Kirsch 1999). Participants are never to be forced in any direct or indirect ways and are required to give informed consent to their involvement in research. Therefore, a consent form was prepared in simple language in English, Bangla, Hindi and Urdu outlining the purpose and procedures of the research in hand. Participants were offered the options to refuse to participate or answer any specific questions during the interview, or to withdraw at any time with no consequences. The form was attached along with the advertisement message in the e-mail to recruiting agencies so that it could be available for clients to look at and read at the agency office. In attempts to allow women at least 24 hours to decide to participate and sign the consent form I emailed it beforehand whenever possible, occasionally to the email address of a family member when the woman did not have one. Often I left copies of the form (in different languages) with women already interviewed to distribute among friends or relatives. Otherwise the objectives and procedures, especially the required time and options were explained over the phone (in a couple of cases to a family member) before the face-to-face meeting with the participant. Only one woman requested the interview questions before the meeting and I emailed her the interview protocol. Before starting the interview I made sure the participant understood and signed the consent form. The conversation was audio-taped with participants’ permission and only one woman refused to be
taped. Women who agreed to be taped were given the choice to ask me to stop the recording at any point of conversation if they felt the need. Only one woman asked not to tape a certain part of her conversation.

In a couple of circumstances, however, allowing 24 hours before getting the consent was not possible. In both situations the participants were invited by a fellow participant rather than directly approached by the researcher. One is already explained in the previous section on sampling and procedure. On another occasion I went for an individual interview and was surprised to see an elderly lady with the participant, who introduced her as a neighbour. I had not been informed about her neighbour even when I confirmed the appointment with the original participant via phone before setting off to her place. I also found the elderly woman to be quite suspicious about me and my purpose. She was concerned if I worked for the government and would report to the government – a concern I noticed with a couple of other elderly Punjabi women lacking formal literacy. Although the main participant explained and assured her about my motives in front of me in Punjabi, I still noticed her discomfort or lack of confidence and reassured her that she had no obligation to participate. The main participant, younger, educated and skilled in English, signed in the form on her behalf (the elderly lady did not know how to sign her name) and insisted that everything was all right and I should proceed with the interview. Meanwhile, the elderly woman took the form to her husband who was present inside the house and came back quite satisfied as her husband approved it.

This showed the limited scope of receiving written consent from South Asian women who are deprived of basic literacy. A few other participants could not read or write or sign their names as well. Therefore, an oral consent was received from them. In one case where the participant could understand and speak English, I read and explained the consent form to her before she had signed on it although she said that her husband also had read and explained the form that was emailed to her address earlier. In other situations I made sure that the interpreter explained the research process to the women. Thus I proceeded in the most ethical way possible under the given circumstances. There were a couple of women who had no formal schooling but could barely sign their names. Under such circumstances information in the consent form was reviewed verbally by a fellow participant or a family member. In a group interview the South Asian support worker who provided interpretation signed on one woman’s behalf. The woman
had known the support worker for a long time and this was not the first time she signed on the woman’s behalf. A family member or friend signed for the other women and in all cases they were quite used to and comfortable with this process. I always tried to make sure that the family member or friend explained the research purpose and procedure well to the woman before signing on their behalf. I also checked if the women had any questions about any aspect of the research. A few times I realized that women used a different name (pseudonym) to sign on the consent form.

To ensure confidentiality and protection of identity, all the participants were assigned, for identification, a two-digit serial number with different initials expressing the interview setting (IN for individual, CI for couple and GI for group interviews). Additionally participants were given an option to choose pseudonyms for themselves. Eleven women self-picked a pseudonym – only one woman gave herself a pseudonym in an individual setting whereas most women in the group settings chose to give themselves pseudonyms and had some fun over this process, except the group of Pakistani women. Feminist researchers usually oppose the dehumanization of individuals through the imposition of numbers for the purpose of identification of participants. Therefore, I decided to give pseudonyms to the rest of the participants. I selected the names of 20 South Asian flowers that represent common South Asian female names and then assigned them in alphabetical order to the sequential list of participants. This process ensured the neutrality essential for protecting the participants’ identity given that names (even some flowers’ names) often reflect ethnic, religious and class positions. Furthermore, all possible identifying information was removed from the written reports. Descriptive and demographic data such as age, educational status or religion were only included in reports when they were deemed relevant and important to the presentation of the data, or necessary for the sake of contextualizing certain findings within the socioeconomic milieu. Special care was given to leave out those kinds of details that might cause a particular woman to be identified within a small community where people tend to know each other well. The detailed information that might cause particular woman with specific medical history to be identified by healthcare workers were not revealed either. Confidentiality was further maintained through careful handling of data. All interviews were transcribed and translated by the researcher. Additionally, hard copies of the data were stored in a locked cabinet at the UBC Centre for Women’s and Gender Studies. Electronic copies were saved in a personal computer protected with password only accessible to the researcher.
Participants were also asked if they wanted to see their interview transcripts. Most women had a negative response while a few showed interests in the transcripts and a few in the final written report. The members of the support group in the community agency requested a formal presentation of the research report upon completion. Participants received a small token payment ($20.00) in appreciation of their time and assistance with the study. Some were provided with childcare and/or travel expenses in order to facilitate their participation. The anticipated risks of taking part in this study were minimal including raising distress while talking about difficult challenges of immigration and settlement or worries about breast and cervical cancer. One recent immigrant became quite upset while talking about her unemployment and financial stress, but at the same time appreciated the opportunity to share her experiences and feelings and to relieve some of the negative emotions. She also made some strong recommendations to improve the immigration, employment and healthcare systems for immigrants and wanted her voice to be heard by the Canadian government and policy makers. Most women who did not have any knowledge and information about cancer screening appreciated the opportunity to know about the issue through the interview process. I had some pamphlets about Pap smear and mammogram in English and Punjabi and women who did not know or wanted to know more about these were supplied with these information.

Analysis of the Data

Data analysis refers to the process through which data might be turned into ‘evidence’ that can be used to assemble conclusions or arguments, and explanation or interpretations (Mason 2002). As data cannot just make sense by themselves, they need to be organized, analysed and interpreted in light of the research questions as well as the theoretical and methodological perspectives. Information gathered and generated through in-depth interview questions formulated to answer the research questions constituted the basic data for the project in hand. But the data analysis did not start after all the data had been collected; rather the process was continuous, flexible and often concurrent with data collection. The analysis began with the re/framing of research questions as well the interview layout, selection of methodological and theoretical approaches (i.e. before the data collection) and continued through collection, transcription, re/organization and re/writing or re/presentation of data. While the pre data
collection processes influenced the nature of data collected, early analysis of the data facilitated “generating strategies for collecting new, often better, data” to fill in gaps (Miles and Huberman 1994, 50) – for example, through theoretical sampling.

Coding, or sorting, combining and differentiating data along different but interrelated themes or categories, is not just a technical task, but also constitutes an important part of analysis. As Mason put it, “cataloguing and indexing systems are not analytically neutral” (2002, 148). She also suggested that codes should be loose and flexible groupings rather than concrete, uniform and static categories. The coding categories in the present study were initially constructed in the light of the research questions as well as the interview guides and in relation to pertinent literature and overall theoretical and methodological perspectives. But they were mainly drawn inductively from the data and then revised and grounded in the data through iterant and reflexive readings. Reflexive reading means reading through or beyond the data, to be able to infer what they imply – not only what the text actually contains but the implications and what is not literally present in the text (Mason). This demands paying attention to contextual information as well as implicit norms or rules with which the participants operate or discourses by which they are influenced. Such reading also involves thinking about the process of data production, locating the researcher as part of the data generated, and exploring the roles and perspectives of the researcher in the process of interpretation of data. In fact, the researcher’s role is inevitably and inextricably implicated in the data generation, categorization and interpretation process. Although many qualitative researchers, as Sipe and Ghiso noted, frequently obscure their own involvement in the creation of conceptual categories, in fact, they insisted, “we don’t discover conceptual categories in our data; we build them” (2004, 474; emphases added). These authors suggested that we must be clear that category-building involves our subjectivities and therefore demands reflexive explanations throughout the process of coding and analysis of data.

A preliminary list of codes was constructed while transcribing the interviews. Then the interview scripts, demographic profiles of the participants and my reflexive field notes were entered for coding into MAX QDA, a software for analysing qualitative data. This provided a helpful tool to better organize and categorize the data and manage the coded segments that could be easily retrieved, compared and contrasted for analysis. This also facilitated creating a
mechanism for moving back and forth between the research questions, theoretical approaches and all the different kinds of data so that coding categories and coded segments of data could be revised, reorganized and re/interpreted through this interactive process (Mason 2002). The initial coding categories were mostly descriptive of the women’s experiences of immigration and settlement and their understandings of and levels of participation in the cancer screening services. But a deeper level of analysis demanded more inferential or interpretive reading of the data, and accordingly, reorganizing, polishing and linking of the codes and coded data segments that led to identification of patterns, themes and explanatory links (Miles and Huberman 1994).

In generating the themes, consideration was given to both similarities among women’s experiences and the contrasts and exceptions to those experiences. Some of the codes and coded data had more theoretical resonance as they were linked with theories and literature that helped explain the ways the multiple and intersecting systems and structures shape South Asian immigrant women’s understandings, access, and use of the cancer screening and other services within the Canadian healthcare system.

Intersectionality theory along with feminist antiracist critiques of women’s health and health inequities provided the much needed lens for viewing the intersections of gender, race, class, age, immigration status and other structures of inequality in the everyday lives of South Asian women. The intersectionality lens was helpful for linking these women’s accounts of subjective experiences to the larger discourses and systemic processes in Canada – to the social, economic, historical and political processes where their experiences are embedded (Bannerji 2003; Man 2002). As suggested by Cuadraz and Uttal (1999, 179), in order to analyze the intersectionality of both the social structures (macro processes) and individual experiences (micro level) of race, class, gender and immigration, the data or women’s narratives needed to be read for identifying –

- Individual locations – how the individuals understand their experiences and explain their situational locations.
- Social locations – how histories of race, class, and gender stratification (and other structural forms of domination) have shaped contemporary social locations for the social group the particular individual represents.


Cuadraz and Uttal pointed out that from the intersections of race, class and gender perspective, to simply present the voices of those studied is not enough; the voices and individual accounts can be contextually located in history, place and structured social locations, and further synthesized with knowledge about historical and structural analyses. Incorporating historical information, findings from previous studies and theoretical statements about social categories and power relations can be helpful in analyzing the data. Furthermore, as Bishwakarma, Hunt and Zajicek (2007, 9) remarked, intersectionality as a method of analysis attempts to deal with “the way that specific acts and policies address the inequalities experienced by various groups” (cited in Hankivsky and Cormier 2009, 32). Thus the individual experiences of the participants or South Asian women were linked to or situated within historical as well as current contexts of Canadian immigration policy, multicultural policy, neoliberal and global economic policy of healthcare reform, in order to understand their relationships with and impacts on immigrant women’s health and access to health care including cancer screening services. Such an approach was useful for addressing the research question that aimed to explore the ways in which the broader systems and structures shape South Asian immigrant women’s access to and experiences with cancer screening services in Canada.

**Representing the Voices of South Asian Women**

Critical feminist researchers have extensively debated about whether and how to claim a true representation of research findings or reality which is rather viewed as a social construction (Fonow and Cook 2005). While historical realism holds the view that knowledge of social reality is produced in particular social, historical, political and intellectual conditions and situations, social constructionism believes in multiple interpretations or more than one perspective or argument about realities. As my research design has been shaped by the ontological and epistemological positions of historical realism and social constructionism, and by a subjective rather than objective point of view, I acknowledge that the findings of the current research are incomplete, partial and situated within the research relationships and processes. However, feminist methodology involves explaining and justifying the design and techniques used in feminist research; therefore feminist researchers need to stand behind their use of particular methods and techniques in order to claim the credibility or rigor of the data produced and interpreted through the research. This is also important because qualitative research is in many
ways a marginalized methodological discourse, and qualitative researchers cannot escape addressing their position and foundations in relation to quantitative and positivist methodologies and traditions (Edward and Ribbens 1998). As nurse researcher Sandelowski clarified, rigor or validation, particularly in context of qualitative research, is less a matter of claiming to be right based on “rules assumed to be sufficiently abstract and universal for every project” – it is a matter of having practiced “good science” or logic relying on “contextually grounded linguistic and interpretive practices” (1993, 2). It does not reflect the subjective or objective stance of the researcher, and rather indicates the soundness or accuracy of the data or research findings themselves (Sandelowski 1986).

Reflexivity or the practice of exposing the researcher’s positionality and the part played by the researcher in constructing the data is a common feminist approach to negotiations over certain knowledge claims (Dyck and McLaren 2004; Ramazanoglu and Holland 2002). Reflexive research practices involve critically situating oneself as a researcher within the process of knowledge production through disclosing the subject positions, histories, influences, beliefs, and morals, and being self-critical, thoughtful and sensitive in all interactions with participants and in representing their lives. It also means that instead of hiding the moments of discomfort and dilemmas in our research, feminist researchers should disclose these dilemmas through sharing and exchanging information and experiences about how they make decisions, and about what they have learned during the research process (Kirsch 1999). I have adhered to this feminist tradition and practice through documenting reflexive accounts of my social locations with a special focus on my varying degree of insider/outsider status within South Asian community, and also through revealing my personal, intellectual and political interests in the issue or research topic. I have also reported the methodologic challenges and dilemmas I faced in doing the research and the strategies adopted to overcome or address those as well as the limitations of the study. Furthermore, Sandelowski has suggested that “achieving auditability” is an important strategy to achieve rigor or “confirmability of qualitative research,” and this simply means “describing and justifying what was actually done and why” so that any reader or another researcher can follow the progression of events and the logic behind those events in the study (1986, 34). In this research, auditability was ensured through incorporating and demonstrating in the research report the accounts of – how the researcher became interested in the subject matter of the study, how the researcher viewed the things studied, the specific purposes of the study,
how the participants came to be included in the study and how they were approached, the impact
the participants and researcher had on each other, how the data were collected and how long data
collection lasted, the nature of the settings in which data were collected, how the data were
reduced or transformed for analysis, interpretation, and presentation – many of the approaches
offered by Sandelowski.

However, I shared the same concern raised by Kirsch: “Can researchers understand and
represent the experiences of others without misrepresenting, misappropriating, or distorting their
realities?” (1999, ix) because I maintained the sole power of representation by being primarily in
charge of mapping the research design and analyses as well as writing reports. My analysis has
obviously been shaped by my personal and social locations, the research objectives and questions,
my understanding of women’s experiences as well as relevant theories and literature. But I have
endeavoured to bring the women’s experiences at the center of analysis and to ground the analyses
on their diverse perspectives and voices. I have also tried to present the diverse perspectives,
experiences and voices of South Asian immigrant women through maximizing the use of
eamples, quotations and excerpts of their narratives in the report. Attempts were made so that
all the women were cited at least once, and efforts were taken to ensure that no women’s voices
were excluded. But some women have been mentioned more frequently than others and the
voices of all participants were not equally highlighted; especially the voices of those with the
facility in English as well as in articulating experiences have been overly cited or represented.
Instead of citing verbatim quotes of women’s voices, these were edited for clarity, coherence and
grammatical correctness where necessary. This was not to ‘speak on behalf of the women’ but in
consideration of the effects/consequences of the research on participants, on public discourse,
and on policymakers (Kirsch 1999), and particularly to resist the dominant perception and
representation of immigrant women as ignorant or weak in spoken English. Besides, in order to
avoid essentializing and homogenizing the experiences of South Asian immigrant women in the
study, I sought to identify differences in women’s experiences as well as to understand whether
and how those experiences were influenced by the diverse socioeconomic contexts of these
women’s lives. But at the same time it was necessary to emphasize their shared legacies of being
the ‘other’ while simultaneously recognizing their varied levels and degrees of agency and
resistance.
Frith and Kitzinger insisted that qualitative data, or “talk-in-interaction,” is constructed in relations with others – researcher as well as other participants in a group, and therefore, any claims about the meaning of what participants say should be made carefully with a recognition of their specific social interactive context in which data are produced (1998, 301). Frith and Kitzinger also cautioned that no data is produced in a neutral and disinterested way by research participants; rather participants pay attention and adjust to the questions, concerns, assumptions, interpretation and judgements of others in producing their talk. As such special care was taken throughout analyses, interpretation and presentation, to contextualize individual, couple and group interview data as being produced in contexts of interactions within group members as well as with the researcher and interpreter. When citing examples of women’s experiences and perspectives I tried to include as much relevant contextual information as possible.

In the case of analysis and interpretation of research data, feminist researchers such as, Kirsch (1999) suggested collaboration with participants, particularly in order to avoid myriad of ethical problems ranging from disagreement over meaning of data to conflicts in interests, values and ideology. She believed that the interviewee/participants should be invited to co-interpret data and provide their input in analyzing the data. While obtaining validation from the participants themselves through participant collaboration and member check is an important strategy to achieve credibility of qualitative data and interpretation, the present study attempted but received very limited success with this strategy. This strategy can be especially challenging when the participants do not have literacy, let alone feminist or critical consciousness, or simply the time and interest to participate in the process of data analysis. I had asked the participants if they would like to get a copy of their transcripts or to give any input in their transcripts. Six women wanted a copy of their transcripts. The original English transcripts of two interviews and the translated English copies of two other interviews were emailed to the interested interviewees. They were asked to verify the original or translated contents of the transcripts. Only one of these women replied with an endorsement of the content and an updated information about her physician. Also the first group interview transcript was emailed to the support worker at the community service agency for her feedback but no response or comment was received. Due to communication difficulties it was not possible to send the interview transcript to the two other interested women. None of the participants were asked to collaborate on the analysis of data, or
to provide any input or feedback on my interpretation of the data because it did not seem to be feasible given the time and other constraints.

The accuracy or soundness of the interpretation is also dependent on the validity or credibility of the data. While all the data were co-constructed through the interactions and negotiation between the participants and me (the researcher), this data generation process was further layered and challenged by the language barrier I encountered in interviewing women who spoke only Punjabi. I was able to compensate my lack of familiarity with Punjabi and partially overcome the language barriers in interviewing those women with the help of a community support worker, some fellow participants and family members who offered interpretation of the interview conversations. But I was not always content with this process or outcome. The following excerpts from my field notes will shed some light on the language barriers and some of the other challenges I faced in interviewing most of the elderly participants (Oct 03/09):

The daughter-in-law sounded very friendly and spoke very good English. She also offered help with the English interpretation and I felt confident about this by her spoken English skills demonstrated over phone … Both participants were from Punjab, Pakistan and only spoke Punjabi. Malati (mother-in-law) had some understandings of my Urdu and I could understand some of her answers in Punjabi and we had some direct conversations. But the other lady, Lily (Malati’s neighbor) was older, very quiet and looked a bit annoyed and she said she would have to go home to make roti (chapatti) for lunch for the family. Lily’s husband passed away 18 years ago and she was dependent on her son and other children. She lived in a big extended family of 11 people. So I let her go earlier and continued conversation with Malati. She had a much amicable gesture and she also looked interested in the topic. Overall she was much more articulate than Lily, who at the beginning talked a little but gradually became even quieter. I suspect it might be because of my inability to communicate with her directly in Punjabi. Overall, the quality of the interview didn’t feel great to me. […]

The daughter-in-law was doing okay with the interpretation, but I felt like she was not giving me all the details and was only giving me the gist or summary of the participants’ responses. She always had a frown and she was watching over and talking to the kids while we were talking, and she looked stressed. When I asked her if she had any problem she mentioned smiling that her husband had returned home in the morning after the night shift of his security guard job and he was sleeping in the bedroom. She just wanted to make sure that the kids wouldn’t go to the bedroom and disturb their father. When I apologized for the inconvenience she assured that it was not a problem and that they were pretty used to having people or guests over during the day when the man of the house slept. Her father-in-law also worked as a security guard and had recently been laid off. […] I offered the daughter in law a small participation fee ($20.00) as my deep appreciation of her volunteering with the interpretation despite all the challenges of
watching the kids and managing other household jobs at the same time. She strongly refused and looked very uncomfortable or shy. But the mother in law came in and took the honorarium.

Thus the translation or interpretation provided by untrained family members was influenced by their own understandings of health issues and cancer screening tests, personal views and values as well as the circumstances of the interview. The interpretation as well as representation of certain voices was also shaped by the kind of relationship women had with their daughter/in-law, neighbour or the community support worker as well as myself (the researcher). One of the women who helped during the interview with her mother was a practicing nurse. She and the South Asian support worker in the first group interview shared their perspectives and views on the research topic in addition to providing interpretation help and I believe this has enriched the data. But in some situations family members or neighbours often tended to speak on behalf of elderly women underprivileged by lack of basic literacy and English language skills. As already mentioned, these women appeared to be quite accustomed to the process of someone interpreting or even speaking on their behalf. Should this be considered as my failure to generate first person accounts or to represent the voices of some participants? Here is what I wrote in one of my reflexive field notes in this regard (Oct 18/09):

My inability to speak and understand Punjabi could have been addressed by adequate funding to employ a professional translator. However, this also provided valuable contextual information or data about the status of these women that I had not planned to acquire. Children have historically spoken for their racialized parents, especially for mothers who don’t speak English in the courtrooms, hospitals, schools and other institutions as well as in everyday life settings where communicating in English is required in Canada.10 This is an example of the social contexts of many immigrant women’s lives in Canada. It also enabled me to view the data as constructed in the social contexts of relationships, which shape many South Asian women’s lives (such as, between mother/in-law and daughter/in-law or between neighbours, and between the participants and me). I believe this is the power of qualitative research, which emphasizes the significance of the contexts, particulars and nuances of the social world.

Nevertheless, rather than expressing “empathy with [participants’] potential language problem” (Marshall and While 1994, 568) in a face to face conversation, I always apologized to the participants for not being able to speak Punjabi so that the participants did not feel the lack of

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10 I was reminded this point by Benita Bunjun, my colleague at the UBC Center for Women’s and Gender Studies.
English or Hindi/Urdu as their shortcoming. As Marshall and While pointed out, without a common language, communication within the interview setting can present particular problems such as superficial interaction regarding participant’s views and inaccuracy of meanings. Misunderstandings may also occur over meanings of a word or concept particularly with reference to technical terms. The quality of the interview interactions as well as data seemed to be much better when the interview was done in the mother tongue of the participants. I translated these interviews in English while transcribing. Much of the meanings of qualitative data are embedded in contexts; therefore I tried to pay close attention and care to the nuances of language and socio-cultural contexts during the translation process. As a native speaker of Bangla I felt very confident about translating these conversations (in three single interviews and two field notes) while there was little translation of Hindi/Urdu conversations which were mixed with English conversations in one couple and one group interview settings. Most young and educated participants as well as all of the interpreters (either professional or family members/friends) were multilingual or at least bilingual. And as a multilingual South Asian researcher, I had some advantages – whenever there was any confusion about any particular words (English/Punjabi or other) we could take resort to more than one language to clarify the issue. As both the participants and I spoke English as a second language, I did not have any challenge understanding South Asian English accent and the participants did not have problems with my accents either when the interview was done in English. Back translation is the most common and highly recommended procedure to assure accuracy and validity of any translated research instruments or texts, mostly used in quantitative studies. But no back translation was possible for the current translated qualitative interview data because such interviews are extensive and take immense time and energy to translate and transcribe, and access to bilingual experts for back translation and verification involves costly, time-consuming and lengthy processes. Therefore, I acknowledge that the translated data may be ‘biased’ and may not be able to represent the ‘true voices’ of the women. It was not possible to translate the technical words like Pap smear and mammogram or cervix/cervical into any South Asian language and therefore transliteration was used where necessary. Due to lack of understanding about mammogram and Pap smear among some elderly women there were some confusion about their use or lack of use of these services. This has been illustrated in the next chapter.
**Feminist Objectivity/Subjectivity**

Based on Haraway’s theorization of “feminist objectivity” or “situated knowledge,” Bhavnani (2004) has developed three principles or criteria against which to evaluate social scientific enquiry for its claim to be feminist; as she insists that simply because the main “agent” of any self proclaimed feminist research is a woman, cannot be a sufficient ground for such a claim. A feminist research, according to her argument, must show “feminist accountability” (effort and care taken not to reproduce the researched in ways they are represented within dominant society which re-inscribe inequality); “partiality” (whether and how the research report makes reference to the “micropolitical” processes of power which are in play during the conduct of research); and “positioning” (in what ways the questions of difference are dealt with in the research – in its design, conduct, write-up, and dissemination).

Although the notion of feminist objectivity may sound paradoxical it actually strives to establish subjectivity as a valid ground for justifying truth claims. At the same time, it also rejects the postmodern and poststructuralist thought that “abandons any notion of methodology as able to produce knowledge that describes actual reality” (Ramazanoglu and Holland 2002, 4). And ‘objectivity’ here seems to mean the soundness or authenticity and credibility of the knowledge produced through particular research, and not to a value-free knowledge. In this sense it is a negotiation between positivism and absolute relativism and a strategy to claim validity of feminist knowledge while viewing all knowledge as partial, socially constructed and historically situated. While there is more than one way of making and justifying knowledge claims (Ramazanoglu and Holland), mapping out the contours of feminist objectivity provides an important tool to tackle the deadlock over questions of “objectivity” and “truth” (Bhavnani).

Much research, although done by women for or with women, whether they claim to be feminist or not, has ended up stereotyping and ‘othering’ racialized women. For example, the existing literature on South Asian women’s cancer screening behaviour, because of its overemphasis on cultural factors and decontextualization of larger structural issues, have constructed such women as a homogenous category and maintained white Canadian culture as the norm against which to evaluate or understand other minority cultures. The current research used antiracist feminist approaches to counter the reproduction of cultural essentialization and
stereotypical representations of South Asian immigrant women through highlighting their internal differences and diversity, and as well, to examine the broader racializing and gendered processes and policies that impact these women’s access to health care including reproductive cancer screening. This is an attempt to pursue Bhavnani’s (2004) “feminist accountability” (for advancing the projects of feminism and “feminist objectivity”), through complicating and problematizing the dominant representations of South Asian women as the ‘victim’ of their culture. The current study’s focus on an intersectional analysis of South Asian women’s experiences as shaped by both advantages and disadvantages of immigration and their varied interactions with race, gender, socioeconomic class, religion, age and other levels of inequities helped to acknowledge and portray women as active agents rather than passive victims of structural forces. Moreover, the issues of difference have been at the heart of this research, not only among participants but also between the participants and myself as a researcher who is also from a South Asian background. As such I tried to remain conscious and reflexive about the power relations: not just the ones stemming from different positionalities of the researcher and the researched, but also power exerted during the research process (defining the research relationship, unequal exchange and exploitation) and power exerted during the post-fieldwork period in writing and representing (Wolf 1996, 2). Ultimately, I intended not only to integrate into this research women’s personal perspectives and voices regarding their health experiences and access to health care, but also to situate those issues within their experiences of migration and settlement and within the broader intersecting historical, socioeconomic, political, and healthcare structures, discourses and processes, with the goal of attaining equity and justice in health care.
CHAPTER 4: SOUTH ASIAN IMMIGRANT WOMEN’S PARTICIPATION IN CANCER SCREENING

Introduction

This chapter showcases the varied and complex ways in which the South Asian immigrant women in this study participated in breast and cervical cancer screening processes. It also discusses the various intersecting influences that appeared to have shaped the women’s use and lack of use of Pap smear and/or mammography services, and to some extent, clinical breast examination (CBE) and breast self-examination (BSE). Women’s understandings of and experiences with the cancer screening processes are also discussed. Women’s varied levels of participation in breast and cervical cancer screening indicated that several interconnected influences and complex, entangled issues facilitated or hindered their use and/or lack of use of reproductive cancer screening as well as their participation in CBE and BSE. Rather than compare or generalize about women’s use and lack of use of cancer screening, the main purpose of this chapter is to present the overview of women’s narratives and to describe the key findings with regards to women’s differential engagements with breast and cervical health, prevention and screening of breast and cervical cancers. The numerical data were derived from this small sample only for descriptive purposes in order to reflect the noticeable profiles and patterns of use of cancer screening among the participants. Therefore, these numbers do not demonstrate any statistical significance or generalizing power, but rather set the context for deeper understanding, analyses and interpretations.

Women’s use or lack of use of cancer screening seemed to be influenced by multiple intersecting factors including women’s age, immigration, educational and generational status, literacy and English language skills, knowledge and awareness of female cancers and cancer prevention, access to community resources and services, not/having a family history or symptoms and perceived need of cancer screening, gender roles and responsibilities, certain beliefs about health and illnesses, not/having a recommendation from physicians, and the role of physicians in providing cancer screening and other care. Women who participated in the current study came from various socioeconomic positions, religious, linguistic, educational and
occupational backgrounds; but analysis of their different levels of participation in cancer screening indicated complex interconnections among age, length of stay in Canada and education/literacy/English language skills. In general, younger women and long time residents were more likely to use these services compared with the older women and recent immigrants. Younger women also tended to be more educated and knowledgeable or aware of prevention of reproductive cancers. However, irrespective of women’s age, length of residency and English skills or level of education, physicians had initiated and managed the screening processes for the majority of the users while most of the women who did not use cancer screening in Canada had never been informed or recommended by their physicians to do the tests. Despite a variety of beliefs and perspectives among the women about prevention of cancer and cancer screening, one of the most important influences on their participation in cancer screening appeared to be the perceived importance of physician recommendation. Women’s narratives did not reflect any unified South Asian cultural health beliefs that determined all these women’s understandings, attitudes and practices around the issue of cancer screening. Women’s personal understandings, use or lack of use of cancer screening services were in fact diversely shaped by many intersecting systemic issues and structural processes, such as, women’s differential access to education, health information, employment, social services, community resources and social capital (such as friends and connections), clinical practices of family physicians, the nature of physicians’ relationship with women and the level of their involvement in women’s cancer screening. But before examining the interconnections between women’s use or lack of use of cancer screening and the systemic and structural issues, the nature and extent of women’s involvement in different cancer detection or prevention practices, and the various intersecting factors that influenced the different levels of those involvements will be discussed.

The Nature and Extent of Women’s Participation in Cancer Screening

Eighteen out of 31 women in the study reported to have used just a Pap smear or a Pap smear along with a mammogram at least once in Canada. Sixteen women in total used a mammogram with or without a Pap smear test in Canada at least once. Thirteen women used both Pap smear and mammogram, while five women used just a Pap smear, and another three women used just a mammogram as shown in Table 4.1. A total of eight women had never utilized any of these tests in Canada. Eleven women never used a Pap smear while two were unsure of such use. Similarly,
eleven women never had a mammogram while four women were ineligible for preventive use of mammogram because they were not yet 40 years old. A majority of the women in the study were using both of the cancer screening tests compared to a small number of women who were using only one of the tests and not the other. Another study by Bryant, Browne, Barton and Zumbo (2002) also found that women having had recent mammograms were much more likely to have also had recent Pap tests in BC, although a very few studies have looked at both of these reproductive cancer screening approaches together. No known studies have explored South Asian women’s participation in CBE and SBE along with mammogram and Pap smears.

Table 4.1: Level of Utilization of Breast and Cervical Cancer Prevention/Detection Processes in Canada

<table>
<thead>
<tr>
<th>Prevention/detection processes</th>
<th>Yes*</th>
<th>No</th>
<th>Not sure/Not known</th>
<th>Not applicable (aged under-40)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pap smear</td>
<td>5 [13]</td>
<td>11</td>
<td>2</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Mammogram</td>
<td>3 [13]</td>
<td>11</td>
<td></td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Pap smear &amp; Mammogram</td>
<td>13 [5+3]</td>
<td>8</td>
<td>2</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Clinical Breast Exam</td>
<td>7</td>
<td>21</td>
<td>3</td>
<td></td>
<td>31</td>
</tr>
<tr>
<td>Breast Self-Exam</td>
<td>10</td>
<td>18</td>
<td>3</td>
<td></td>
<td>31</td>
</tr>
</tbody>
</table>

*For both preventative and diagnostic purposes in Canada

As Table 4.1 shows, only seven women had clinical breast exams done by their physicians in Canada although BC Cancer Agency recommends that women over age 20 should have a doctor examine their breasts once a year as part of a general physical examination (BC Cancer Agency 2010). Although data about three women’s participation in CBE and BSE is unknown, 21 and 18 women never had CBE and SBE respectively. Five of the seven women who had clinical breast exams done had some symptoms or concerns about their breast health. Two of the seven women were below the age of 40 and the rest were over-40 years old. Four of these seven women also had a mammography done in Canada. Only one woman often had asked her family physician to do clinical breast check-ups because of her concerns but she did not do a mammogram, while physicians had initiated a clinical breast exam for two women in absence of any symptoms.

More women (10 in total) mentioned having a BSE at least sporadically as compared to
the number of women reporting a clinical breast exam (seven in total). Five of the women who were practicing breast self-exam were using mammogram tests as well. Four other women, who inconsistently did a self-exam, never had a mammogram in Canada, but two of these four women had a mammogram screening outside Canada due to some concerns. A couple of women who were not using mammograms and/or Pap smears in Canada were somewhat aware of their breast health and often practiced self-exam, though not regularly and probably not very accurately, to check for any palpable lumps in breasts. For example, Kulbir, a retired primary school teacher from Punjab, India, did not have a clear understanding or use of a Pap smear or a mammogram, but she said she occasionally did a self-exam. Her daughter, a registered nurse, was surprised to hear that: “You do! Oh, good!” The daughter commented, “They hear things from here and there. I think she might have seen that from the TV and all that programs.” Similarly, Dev, a 76 year old elderly woman with no formal education or English language skills, never had a mammogram; but she mentioned having occasional self-checking of her breasts for lumps. And her daughter also said, “You know, sometimes in the community centres, some people give information, you know, for the check-up – they tell people how to check your own breasts. She must have seen from there.”

The majority of the women in the current sample used cancer screening tests for a routine purpose to prevent future concerns while a few women used either or both of them because they had some concerns or a family history of breast and/or cervical cancer. A comparison of the preventative and diagnostic use of cancer screening tests in Canada among the women is shown in Table 4.2 below. Only two women in the study had used all of the breast and cervical cancer detection processes (CBE and BSE, mammogram and Pap smear) and both of them had some concerns related to either breast or cervical health.

Table 4.2: Preventative and Diagnostic Use of Pap smear and/or Mammogram in Canada

<table>
<thead>
<tr>
<th>Purpose of use</th>
<th>Prevention (no symptoms)</th>
<th>Diagnosis (symptoms)</th>
<th>Total (N=31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only Pap smear</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Only Mammogram</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Both Pap smear &amp; Mammogram</td>
<td>11</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>None/not sure</td>
<td></td>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>
Some of the women in the study had used the tests for a diagnosis of relevant symptoms in a different country (Australia, India, the UK and US), but not in Canada. A couple of women had used a mammogram in a third country (other than Canada or their home country) for a diagnostic purpose but did not continue the screening process in Canada. On the other hand, a couple of other women had initiated mammogram in a different country due to a symptom and then followed up with the screening process in Canada. Another couple of women had done a Pap smear test in a third country where they were studying and staying over a relatively long period of time, but none of them followed up in Canada where they came as skilled immigrants. Women’s use or lack of use of one or both of these tests only in Canada has been represented in Tables 4.1 and 4.2.

Eight women in the sample were under the age of 40 and therefore were not eligible for a routine mammography in British Columbia. But all the under-40 year old women were asked about their involvement in CBE and BSE in order to know their breast health practices. Three women among all the participants were over-70 years old and they were no longer recommended for a Pap smear. It is recommended that women in British Columbia begin cervical cancer screening with the onset of sexual activity and after three consecutive normal Pap smears every year, continue screening every 2 years until age 69 (BC Cancer Agency 2010). But all of these three women had lived in Canada for 15 years or more, hence it was reasonable to ask them if they had ever used the Pap test and it appeared that the three had never done so. They were still eligible for a mammogram since women aged 40 – 79 are eligible for a free screening mammogram in BC once every 1-2 years without a doctor’s referral (BC Cancer Agency 2010). But unfortunately none of them were using the mammogram service either. Table 4.3 shows the use of cancer screening services among women younger and older than 40 years. Younger women were more likely to utilize cancer screening services, especially Pap smears for prevention of cervical cancer. Even though 10 out of 23 women (43%) over the age of 40, and three out of eight women (38%) under the age of 40 had both of these tests done, all of the eight women who had never had any cancer screening (also shown in Table 4.1) were older than 40. On the other hand, six out of eight younger women were using at least one of these tests, or the Pap test. Only one young woman was not using a Pap smear in Canada although she had used it in a third country before migrating to Canada; and another young woman thought she might have
used it but was not sure. Although women less than 40 years old are not recommended for regular mammography screening in BC, four out of eight women in this age group had mammograms done due to some concerns or a family history.

Table 4.3: Use of Cancer Screening in Canada among Women Under and Over the Age of 40 (N= 31)

<table>
<thead>
<tr>
<th>Age group</th>
<th>Pap smear Only</th>
<th>Mammogram Only</th>
<th>Both Pap smear &amp; Mammogram</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-40 yrs. old (range: 31 – 39) N=8</td>
<td>3</td>
<td>1a</td>
<td>3b</td>
<td>1d</td>
</tr>
<tr>
<td>Over-40 yrs. old (range: 41 – 76) N=23</td>
<td>2a</td>
<td>2</td>
<td>10c</td>
<td>9d</td>
</tr>
</tbody>
</table>

a. One of these women used the test due to symptoms; b. One of these women used both tests due to symptoms while the rest of them used a mammogram due to symptoms; c. One of these women used both tests due to symptoms; d. One of these women was not sure of the use of a Pap smear.

There were mostly regular as well as a few irregular users of these cancer screening services in the present study sample. But data on the regularity of use of cancer screening among women in the sample was very limited. Moreover, it was hard to define or estimate regular use among recent immigrant women who had lived in Canada from one to five years, because some of them had just started using one or both of these services (with possibilities of subsequent regular use). The users as well as the non-users of these tests came from varied backgrounds in terms of their age, religion, socioeconomic, educational and employment status, English skills, and length of residency since immigration. However, the women’s length of stay since immigration to Canada along as well as their age might have impacted their use or lack of use of cancer screening services because women who had lived in Canada longer were more likely to use these services. The use of cancer screening tests among recently arrived immigrant women and women who had lived longer than five years in Canada is presented in Table 4.4. Nine newly immigrated women (length of stay: 1 to 5 years) participated in the study and five of them reported using a mammogram at least once in Canada. None of the new immigrants were using only a Pap smear while two recent immigrants initiated just a mammogram, but one of them had been previously diagnosed with ‘fibro adenoma.’ On the other hand, four of the 21 women who had lived in Canada for at least seven years or longer used a Pap smear and 10 women under this category used both Pap smear and mammogram although a couple of women had one or both
types of symptoms. Although three recent immigrants were using both services, one of them used both tests due to symptoms while another woman did the mammogram due to a concern about her breast health although she used a Pap smear without any symptoms.

Table 4.4: Use of Cancer Screening in Canada among Recent and Long-Time Immigrants (N=30 *)

<table>
<thead>
<tr>
<th>Length of stay</th>
<th>Pap smear Only</th>
<th>Mammogram Only</th>
<th>Both Pap smear &amp; Mammogram</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent immigrants (1 to 5 yrs) N=9</td>
<td>-</td>
<td>2a</td>
<td>3b</td>
<td>4c</td>
</tr>
<tr>
<td>Long-time immigrants (7 to 27 yrs) N=21</td>
<td>4a</td>
<td>1</td>
<td>10b</td>
<td>6d</td>
</tr>
</tbody>
</table>

*aOne woman, a member of a support group interviewed together with the other group members, was born in Canada; hence not included here; a. One of these women had symptoms; b. One of these women used both tests due to symptoms while another under-40 year old woman used mammogram due to symptoms; c. One of these women was unsure of the use of a Pap smear and was not eligible for routine mammography as she was under-40 year old; d. One of these women was not sure of the use of a Pap smear while two women were not eligible for routine mammography because they were under-40 year old.

However, women’s length of residency in Canada also had complex interactions with their level of education. Table 4.5 shows women’s use of cancer screening in relation to their different levels of education.

Table 4.5: Use of Cancer Screening in Canada and Women’s Level of Education (N = 31)

<table>
<thead>
<tr>
<th>Level of education</th>
<th>Pap smear Only</th>
<th>Mammogram Only</th>
<th>Both Pap smear &amp; Mammogram</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate/ Professional (N=11)</td>
<td>3a</td>
<td>2b</td>
<td>3c</td>
<td>3</td>
</tr>
<tr>
<td>Secondary &amp; Diploma (N=11)</td>
<td>2d</td>
<td>1</td>
<td>5</td>
<td>3e</td>
</tr>
<tr>
<td>Primary / No schooling (N=9)</td>
<td>_</td>
<td>_</td>
<td>5</td>
<td>4f</td>
</tr>
</tbody>
</table>

*a. One of these women had symptoms while another woman was under-40 year old, therefore not eligible for recommended mammography; b. One of these women had symptoms; c. Two of these women had symptoms; d. Both of these women were under-40 year old and not eligible for routine mammography; e. One of these women was unsure of the use of a Pap smear and was not eligible for routine mammography as she was under-40 year old; f. One of these women was not sure of the use of a Pap smear.
Among the 11 women with a graduate level education, only three women were using both cancer screening tests. Two of these three women were recent immigrants but they had started using both tests due to symptoms or a family history. On the other hand, out of three highly educated women who never used either of the cancer screening tests, two were recent immigrants, who, nevertheless, had knowledge as well as past experience of using either a Pap smear or a mammogram in a third country. One of the two women with a minimum secondary level education who never used any cancer screening was also a recent immigrant. There was a greater level of use of cancer screening among women with no formal education or with a lower level of education than among women with the highest level of education because most of the highly educated women were also new immigrants preoccupied with settlement issues including finding an employment. Three out of five women with at least a secondary level education and use of both tests were members of a support group where they received knowledge and recommendation about the tests from their community support worker. Women who were least educated were using either both or none of the services. Three women in this category were using both services because their physicians were taking care of the screening processes while the two other users of both services also received recommendation and referral from a community support worker in a South Asian women’s support group. The rest of the women with minimum or no formal education had no use of cancer screening, although one woman was unclear about her use of a Pap test. All of them had a family doctor, and they held their physicians accountable for not initiating or recommending the preventive use of cancer screening tests. Apparently, it was mostly elderly women with limited or no education and literacy, and a majority of the educated new immigrants who were not using either one or both of the services.

**Intersecting Influences on Women’s Participation in Cancer Screening**

The several intersecting factors that seemed to shape women’s varied levels of participation in breast and cervical cancer screening are discussed below. In fact, women’s narratives showed how complex and entangled all these dynamics were in their lives and how the diverse and multiple intersections of these factors shaped their participation in cancer screening services. These are considered as separate influences for the sake of logical organization and presentation of the data although disentanglement of these issues seemed to be extremely challenging.
Women's Age, Literacy and Length of Stay in Canada

Women who used or did not use either or both of the cancer screening services were quite a mixed group in terms of their income and class status, religious background, occupation and country of origin. But analysis of the different levels of use or lack of use of breast and/or cervical cancer screening among younger and older, educated and less educated and recent and long-time immigrant women (presented in Tables 4.3, 4.4 and 4.5) indicated complex interconnections between women’s age, length of stay in Canada and their education/literacy/English language skills – interconnections that positively or negatively influenced women’s cancer screening. Younger women tended to have higher level of education or more knowledge about cancer prevention than the older women did. All of the women under the age of 40 in the study (N=8) had at least a grade 12 level education. Only one of the young women had never heard of a Pap smear or mammogram. On the other hand, nine out of 23 women older than 40 had little or no literacy as well as English language skills and knowledge of cancer screening. However, six of these nine women were using both of the cancer screening services for preventive purpose either because their physician had initiated the process for them or they had been informed or referred by a community support worker to get those tests done. And all of these six women were also long time residents (length of stay 7 to 27 years) in Canada. The majority of the women who had lived in Canada for a longer time period, often despite their lack of education or spoken English skills, were likely to develop increased familiarity about the Canadian systems including health care, and more connections with community service organizations and support groups. Such familiarity and support often facilitated their initiation and use of cancer screening.

Thus overall, younger women and long time Canadian residents were more likely to use these services compared to the older women and recent immigrants. But women with no literacy or lower level of education and poor English language skills had a greater level of use of cancer screening than women with the highest level of education and English proficiency. The majority of the long time residents who never used or heard about mammogram or Pap-test screening were older women lacking English skills and literacy even in their own language and they never received any information or recommendation about cancer screening from their physicians.

Although some older women from rural Punjab of India and Pakistan had lived in Canada for a
good number of years they seemed to be dependent on their sponsors or family members for settlement support, care, treatment and medical decisions. On the other hand, despite the high level of education, English language proficiency and knowledge about cancer screening, a larger proportion of the new immigrants did not utilize either or both of the cancer screening services. More educated recent immigrants were more likely to initiate and use the services when they had some symptoms or family history.

**Understandings and Knowledge of Pap smear and Mammogram**

Data from the current study reflected a complex relationship between participants’ understandings about cancer screening processes and their utilization of the services. In general, women’s level of knowledge and understanding of Pap smear and/or mammogram tests depended on a number of intersecting factors – not only their level of literacy or education and English language skills, but also their age/generation, class, rural/urban settings from which they had migrated, access to community services and support facilities, and the nature of their relationship with their physicians. Elderly Punjabi women, coming from rural India and Pakistan, with limited to no literacy or education and English skills, generally had a lack of knowledge unless they were educated by their physicians or community resource people. For some women, previous experience of living abroad or in a metropolitan area and using the tests at home or in a third country before migrating contributed to their knowledge base, but for some new immigrants it did not ensure utilization of these health services in Canada. Some women were trained and/or working in the health professions so they had the necessary background to have a sound knowledge of these medical procedures. However, having a medical background and sound understanding of these tests did not always make these women’s utilization of cancer screening possible in Canada either. Having knowledge and understanding of these tests often facilitated but did not necessarily guarantee the utilization for all the participants, especially among recent immigrants.

For several women, a lack of knowledge and understanding about female cancer screening seemed related to a lack of use of mammogram and Pap smear as well as CBE and BSE. For example, Salina, the only woman born in Canada and a member of the South Asian women’s support group, mentioned she never had a clinical breast exam done and thought she
was probably too young to have it: “Oh, we haven’t reached that age yet!” The community support worker present in the group discussion explained to her, “When doing your Pap smear your doctor should test pressing your breasts and areas around [to see] if there’s any lumps. So all these should be done; it doesn’t matter what your age is.” On the other hand, three of the nine women who practiced at least occasional BSE, had some sort of backgrounds in health and medical science; hence they had the knowledge about how to do a breast self-exam properly. Gulmohar, a healthcare professional and a very health conscious person, stated, “I regularly physically do the breast checkup myself … so I know that if [there’s] any change, if I notice then it would be imperative to go do the mammogram.” Kasturi, a young woman, though not highly educated, received clear instructions and knowledge about BSE from her family physician and that helped her perform a proper self-exam. She admitted, “Sometimes I forget to do it [self-exam] but I keep doing it usually after 2 weeks form my period.” However, a lack of knowledge of cancer prevention was not necessarily related to a lack of use of cancer screening, particularly a Pap smear and/or mammogram.

Some women with no schooling and literacy as well as no knowledge or understanding of the cancer screening tests were found to have used cancer screening because their physicians were in charge of managing their overall health issues including cancer screening. Some of the women who were using the cancer screening services were often informed or educated about these tests by their family physicians but some were not. As such, most of the participants who used one or both of the cancer screening services had some level of familiarity and understandings about the tests but such understanding was often limited or missing. For example, the medical terminologies (Pap smear and mammogram) did not sound familiar to Malati, a 56-year-old Pakistani woman with no formal schooling or English skills. But I was surprised that when the tests were explained to her she said she had gone through the processes. Malati confidently said, “I’ve done that! The white lady did that… internal test to check for cancer [Pap smear] … yes, it’s been a year. I also did the chest x-ray [mammogram] …!” Yet a couple of women did not clearly know if they ever had a Pap smear – at least not just by the name of it. Having had the test explained they thought they might have done a Pap test. Dev, an elderly woman with no formal education or English language skills thought when she had gone to a hospital once with an abdominal pain the doctors did a thorough exam and at that time a Pap smear might have been done to her. All she could say is that a pair of forceps [chimta] was
probably inserted into her vagina. Dev was not the only one – a few other women, especially elderly women with no literacy, who depended on other family members for visiting a physician or getting other medical help, had trouble clearly articulating the medical processes and indicating the exact time and location of a medical procedure done to them. Zinnia, a relatively young recent immigrant woman with a grade 10 level education, did not have any knowledge of a Pap-test either. Like Dev, she could not tell for sure if a Pap test was done on her ever: “When I had the D&C (Dilation and Curettage) done, then I had some tests done, then … it could have been done. But I don’t know if that was Pap or whatever. I don’t know. My doctor didn’t inform me, right?” Without any understanding of what a Pap smear is, it was difficult for some to definitely know or confirm if it has been done for her.

A number of women’s experiences suggested that their physicians did not clearly explain the purpose or processes of a Pap smear or mammogram even when they performed or recommended them. Kamini, a young single mother who had not finished high-school, asked, “What’s Pap smear? Is it the same as Pap test?” Being assured that they are synonymous, she replied, “Yah, I’ve done that one, yah. But I don’t know what a mammography is. I’ve never done a mammography.” Neither did she have clear ideas about CBE and BSE. She said that her doctor did not tell her to do any self-exam but did a clinical exam for her. She could not remember exactly how many times she had a Pap smear done: “I remember this much that I did it after my son was born. So, but, I didn’t really know why I did that.” She also complained, “Few things you told me – my doctor never explained to me although she does the check-up.” In contrast, her friend, Kasturi said, “But my doctors, I think, are quite good because I do have some knowledge which I received from them because they explain to me.” One woman who received good care and cancer screening services from her family physician assumed that all family doctors inform and arrange these tests for women. Sidney, a 63 year old woman with no formal education and no English skills, claimed that all of her friends and neighbours were using these test because she said, “Everybody knows, family doctor tells you!” Rather than explaining her own understanding about these tests she simply said that doctors know best what these tests are for and what they are looking for or why they are doing these tests. In other words, she did not feel that she needed to know about these tests as long as her physician was taking care of everything.
Most of the women had a family physician who spoke one or more South Asian languages suggesting that language should not have been a barrier in exchanging health and cancer screening related information between the women and their physicians. But the women’s level of education seemed to be an important factor influencing such exchanges. These western biomedical terminologies (Pap smear and mammogram) are quite complicated, especially for women without western education and particularly, English skills. A number of women had trouble pronouncing and memorizing these terminologies. A couple of elderly women with no literacy, who never had a mammography done, confused it with general chest x-rays. For example, Dev, the eldest of all the participants, had many chronic as well as acute health conditions. As such, she had gone through a number of diagnostic and medical procedures including a chest x-ray. But she never heard the word mammography, nor had it done for screening breast cancer ever, but confounded it with the regular chest x-ray. She was also confused about her use of a Pap smear because of her lack of knowledge about the test. Dev’s daughter said, “I don’t think she has any knowledge about these tests.” When asked whether her doctor ever checked her breasts or chest, Lily, another elderly woman with no formal education, said, “When I went to a doctor, the doctor checked my chest with a stethoscope.” Thus she had no understanding about the difference between general examinations of chest and lungs and a breast exam.

However, even a few educated women did not have a clear knowledge of one or both of the cancer screening tests. Kulbir had a diploma in primary school teaching but she did not have a clear understanding and use of a Pap smear and mammogram. She seldom heard the terminologies but said, “I don’t really know what these are.” While talking about mammogram, she mentioned that during her required health screening before receiving the immigration visa something was done on her chest area. Then her daughter, a practicing nurse, who was providing interpretation help, clarified the matter: “No, no! She’s mixing it with ECG. I know that they never do mammogram. No, no, because that’s not communicable or anything, right? I don’t think they order mammogram. They must have done ECG. Yah, that’s for the heart!” Rose, who migrated from Pakistan with a graduate level education and fluency in English, had her Pap tests regularly done by her family doctor who did not explain it very well. She did not gain a clear understanding about the test and its importance until her sister died of cervical cancer –
Rose: actually I didn’t know it for the last 10, no, I think, 5/6 years when I came here. I used to have Pap smear but I never asked my doctor what is it or why she is doing it. But I was having it regularly here. Then my sister got sick in Pakistan and she got cervical cancer. THEN I knew that it is something for cervical cancer - Pap smear – how important it is! Then I came to realize why I didn’t know about it before…my [lack of] knowledge …! ... She was a good doctor. She called me every year to come and have my physical exam. But, I think she assumed that I already know because the awareness is more [common] here.

Thus incidence of cancer among family members or friends, or having some symptoms and concerns seemed to be an important influence on some women’s understanding of these tests. On the other hand, those who actively participated in community seminars, workshops or support groups gained knowledge about cancer screening and mostly were able to ask their physicians to initiate the process of screening for themselves.

Women’s understanding and descriptions about cancer screening was somewhat shaped by their level of education and literacy. A few less educated women described cervical cancer as ‘cancer inside the abdominal cavity’ (pet ki ander jo cancer). One woman explained: “For Pap test a swab is taken to take a sample of ‘liquid’ from ‘inside’.” This was different from the understanding of Mollika, a nurse trained in India: “Pap smear is, like, doctor takes some sample of ‘secretions’ from the ‘vagina’ and sends to the laboratory for examination to see [if there’s] any problem or anything in ‘cervix’.” A few other less educated women did not use the word cervix and confused it with uterus or did not differentiate the two parts simply by referring to ‘inside’ or ‘interior’ and ‘inside the abdomen.’ The uterus was often called ‘the baby bag’ by some women. Although Gunj, another participant, had a graduate level education she seemed to have a bit of reservation about using the word cervix or vagina: “The doctor takes some ‘specimen’ from ‘inside’ to test or check for cancerous element.” Women of all educational levels and language backgrounds, however, almost always used the English word ‘breast,’ and sometimes ‘chest.’ Some women used the Hindi or Urdu word for ‘chest’ (chatee) without using any other indirect or esoteric codes for it. Overall, most women had confusion regarding the age at which one should start doing a mammogram or Pap smear and how often they should be done. Some of the sources of information/knowledge about female cancer screening processes among the participants were noted to be family physicians, friends/relatives, community support worker, community workshop, media (radio/TV, Internet) publicity and brochures. Salina said that she found the brochures on cervical cancer screening through Pap smear quite helpful. When the
doctor first did a Pap smear for Salina she did not have much idea about what was going on. When she asked the doctor answered some of her questions but gave her a brochure to look for more answers –

*Well I didn’t know what was this Pap smear, right? I was just out so embarrassed – what is this, right? What is he [doctor] doing? And I asked him more questions, right, so he explained it, this is what it is, right! And then you can’t go on [that] I need more details, right! Because he has to see some other patients. So he gave me [a] brochure. He said, here, have this and read it over. And so it helped me, yah... And then I started picking up the brochure from doctor’s office and it gave me more knowledge and then I read it over and now I know what I want and what are my needs.*

Salina was the only South Asian participant born in Canada but her experience of family violence and her fluency in Punjabi brought her together with other Panjabi speaking South Asian women in the support group. She identified herself as a South Asian Canadian and a working class single mother. She also spoke fluent English and did not face any language barriers to communicating with her English speaking physician or to reading and comprehending the brochures. However, women with no or low literacy in both English and Panjabi could not get such information from brochures and also expected such information and explanations from their doctors. Having been informed or educated about cancer screening helped some women to initiate the process of cancer screening; yet for some women, educated or not, having a proactive and caring physician facilitated their use of cancer screening and to some extent, their clear knowledge of the issues.

**Having Symptoms or a Family History**

Having any concerning symptoms and/or a family history of female cancer was a major impetus for initiation and use of cancer screening for a number of women. Women with some concerns about their reproductive health or a family history of reproductive cancer had no choice other than asking their physicians for advice or initiating cancer screening either just for once for a diagnosis or for regular monitoring and prevention of future concerns. But not having any symptoms or family history made some women ignore the importance of cancer prevention or fail to raise the issue to their physicians. And women’s knowledge or awareness about breast and cervical cancer also often depended on a history of such incidence among close relatives or extended family members and friends. Some women with no literacy thought they did not know
about the tests because they never had any relevant symptoms, or no one in their family had such cancers, hence they did not need to know about these. Lily said she did not have any idea about breast or cervical cancer because it had never happened to anyone in her family: “In my entire family [khandan] no one ever had this. Allah forbids!” Similarly, Jasmine said she never knew any friends, neighbours or family members having any cancer. Almost all the women who were not using a Pap smear or mammogram did not have any family history of breast or cervical cancer. Zinnia was the only exception – she had a history of both cancers on both of her maternal and paternal sides of the family and still she was not aware of the tests and measures to screen or prevent breast and cervical cancers. All the other participants who had a family history were more conscious, proactive or aggressive in terms of asking their physicians about cancer and cancer screening processes. Rose’s family history and awareness led her to ask the family physician about mammogram although she was under 40 years old; however she did not have clear ideas about who should have a regular mammogram –

My maternal grandmother died of breast cancer. So I used to hear it [mammography] since [then but] I was a little bit confused. Every woman who has a history of this type of disease in the family should have it after 40 or what? ... So, yah, I talked to my doctor last time and she said, when you turn 40 you have it. I don’t know!

A number of women in the study used cancer screening services for a diagnostic purpose in and outside of Canada; a few of these women were diagnosed with benign conditions or mild anomalies. Three women below the age of 40 felt one or more lumps through BSE. On the other hand, a 63 year old woman, who never did a self-exam, had a lump detected in one of her breasts while her family physician was doing a clinical exam. Because of some concerning symptoms such as, feeling heaviness or a lump in breast(s) or having some discharge from breasts, two under 40 year old women used a mammogram once. They stopped there because no problem was detected in their mammography. But as they developed consciousness from going through the process of breast screening and both had “a very good doctor” they thought they would most likely start and continue regular screening when they reach 40. The two other women who had started mammogram screening because of a concern were found to have benign conditions but they continued doing it for the purpose of prevention of future concerns. The 63 year-old woman, who had started cancer screening without any symptoms, was later diagnosed with a non-malignant cyst and she decided to continue regular screenings although she was not quite regular before the diagnosis. On the other hand, three women reported having some symptoms or
anomalies leading to their regular use of a Pap smear. One of these women, Bela had a problem detected during her pregnancy and she described how this diagnosis increased her health consciousness –

*Bela: I, I have fibroid or cyst [in the uterus]. For that reason I have to do it [Pap smear] regularly after certain interval. It’s benign but still I have to do it quite often ... so any change can be detected right away and then I might need a surgery ... When my first ultrasound or ultrasonography [of the foetus] was done during my pregnancy then it was first detected that I had a fibroid along with the baby and that wasn’t a recent thing – it had been there for a long time ... that’s why I had a c-section – planned c-section. And since then I do regular follow-up. For this reason I’m more conscious about my own health so if anything is wrong I’ll be able to take care of that immediately.

Two women shared negative experiences with their physicians when they had some concerns regarding reproductive health. Bimla felt severe pain in her abdomen area, yet she thought her previous South Asian male physician did not pay attention or rather minimized the problem: “The doctor just said that, oh, maybe because you’re ovulating during those days or maybe having this or that or maybe you’re constipated.” But she was very assertive that she had a bigger problem. She said, “No, I don’t think so – it’s because of that! It’s much more than that.” Upon her insistence the doctor referred her to a gynaecologist who found out that she had endometriosis as well as a small cyst in one of her fallopian tubes and ordered a laparoscopy. Since then she continued to get her Pap smear done from that gynaecologist. Another woman, Camellia had started doing Pap tests when she was studying in the US before immigrating to Canada. In her opinion, when a “slight abnormality” was detected in her Pap report, the doctor in the US handled the issue very sensibly and followed up carefully as well as rigorously. In contrast, her current family physician did not inform her about the anomaly found in the test report in Canada until she had inquired about it about six months after the test was done. Both Bimla and Camellia also had a family history of breast cancer and therefore they initiated a mammogram screening. Even though Bimla was under-40 years old and did not have any symptoms she started doing mammograms because she was extra cautious due to the family history. As she mentioned, “I did it first time when my sister was diagnosed with breast cancer. Then I asked my doctor that I too want to do it.” Luckily she did not have any problem diagnosed but continued screening because of the family history.
Physician Practices: “Some Doctors Let You Know, Some Don’t!”

The narratives and experiences of the research participants particularly pointed to the important part family physicians played in initiating preventative cancer screening for women, and in teaching them about the importance of the issue. Only two women in the study did not have a family physician at the time of the interviews. But having a family doctor did not ensure women’s use of cancer screening services. It became clear from the women’s experiences that their family physicians were not using a standard or uniform approach for initiating, educating, recommending and encouraging preventative cancer screening for women – a phenomenon nicely captured by the comment made by Devi: “Some doctors let you know, some don’t!”

A young woman from Pakistan mentioned how she was advised by her family doctor to get a regular physical examination every year and how she was getting her Pap smear and clinical breast exam done as part of this process –

*Poppy: I did it [Pap smear] last week. When I was in Pakistan I didn’t pay attention to this, like, going for a check-up or something. It was so plain and simple over there after having kids! People often don’t go [to the doctor] as much as they do here even when sometimes they have some problem, right! They go probably when it’s intolerable. Here we’re told that it’s good to have a check-up. My doctor told me that every year I should have a check-up. So, I go… My doctor checked everything – blood pressure and breasts and everything!*

On the other hand, both Mollika and Ivy, two recent immigrants went to their physicians for a basic health check up within the first year of their migration to Canada. But neither received a Pap-test or clinical breast exam or any information or recommendation about a mammogram. Mollika said, “No, nobody told me [about mammogram and Pap smear] in Canada.” Ivy, a 53 year old recent immigrant, had a hysterectomy done in India. When she went for her first check up in Canada, the doctor did talk to her about Pap smear. Having been informed about her hysterectomy the doctor said that she did not need a Pap smear any more, without inquiring if she had a complete or partial hysterectomy because in case of the later she might still need a Pap
Ivy did not know what type of a hysterectomy (partial or complete) was done for her and did not have a clear idea if she needed a Pap smear or not—

Ivy: ... he asked me, have you done a Pap smear? Then I said I have done my hysterectomy already 4/5 years ago. So I’ve never done a Pap smear. Then he never said anything. But the Pap smear thing maybe, sometimes, I have to ask him quickly because that is something, like, a lot of people, they get cervical cancer and all that. So, like, I want to go and see because I have NEVER done a Pap, and never done a vaginal test or anything after my hysterectomy.

Ivy also had a mammography done twice in India because her gynaecologist had recommended that she should have regular mammogram after the hysterectomy. Her gynaecologist in India also did regular CBE – “the physical check just touching and all that.” She also had a benign cyst removed from one of her breasts in India. But after coming to Canada, despite her visit to a family doctor for a total check-up, the physician did not talk to her about doing a mammogram: “He also never asked about breast check-up, you know! He never said anything though I have done [that] back at home. I have routinely done mammogram.” The majority of the women who did not have the tests done in Canada held their doctors responsible for not discussing the issue with them. Most women indicated that they would have done it or would do it in future if their physicians asked or recommended. As Zinia, like many other non-users, complained, “My doctor didn’t inform me, right?” Dev demanded, “Doctor should tell me to make an appointment.” Mollika said she would use cancer screening “if my doctor will recommend.”

Having been informed about cancer screening through this study, a few women said they would talk to their doctors about it.

As already shown (Table 4.2), although a few women used the tests for a diagnostic purpose most women were using them as a routine check-up to prevent future problems. For the majority of the women, who used cancer screening for preventative purposes, their physicians took a proactive or leading role in performing or recommending the tests although often without explaining the purpose and procedure. Two broad patterns were noticed among women who

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11 According to a study published in the Journal of the American Medical Association, women who receive complete hysterectomies (removal of the entire uterus, including the cervix), an annual Pap smear is unnecessary. However, in case of a partial or subtotal hysterectomy where the cervix is left in place, a Pap-smear may still be needed and recommended. Source: Pap-Smear after a Hysterectomy, http://www.womenshealthcaretopics.com/pap_smear_after_a_hysterectomy.htm (access date: November, 2010)
were using a mammogram and/or a Pap smear test in Canada solely for preventative purpose –

- Some women were pre-informed and well aware of the cancers and screening services and took the lead in asking their physicians to initiate the process.
- Physicians initiated the screening process and managed everything for the majority of the women. Although some of these women were knowledgeable about these tests, some were not, despite using them.

On the other hand, most of the women who never used any cancer screening tests in Canada were not informed or recommended by their physicians to do so. Overall, two broad patterns were identified among the non-users of these tests in Canada –

- The majority of women were not using the tests because their physicians were not informing or consulting with them. Some women were already knowledgeable about these tests while some were not, but most believed their doctors should advise them and they would do it if doctors recommended and initiated the process.
- A few women were recommended to take these tests by their physicians but were still not using them for various other reasons.

Comparing women’s experiences, especially between those who used the tests and those who did not, it became clear that family physicians played a major role in initiating the routine screening process, especially for those who had no literacy in either English or their own language, and/or no knowledge of cancer screening. Table 4.6 shows physicians’ role in informing and initiating the process of cancer screening for the participants. However, physician practices and their individual relationship with the women should also be understood within the broader socioeconomic and political contexts, structures, discourses and power relations, particularly in the interest of an intersectional analysis. Therefore, an examination of the broader socioeconomic and healthcare policies, structures, discourses and processes that are likely to influence physician practices in Canada is presented in Chapter Six.
Table 4.6: Physicians’ Role Influencing Women’s Participation in Cancer Screening in Canada

<table>
<thead>
<tr>
<th>Preventive use of cancer screening</th>
<th>Lack of use of cancer screening</th>
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</thead>
<tbody>
<tr>
<td><strong>Pap smear:</strong> (total – 15°)</td>
<td><strong>Pap smear:</strong> (total – 13°)</td>
</tr>
<tr>
<td>Initiated by a physician – 12</td>
<td>Informed by a physician – 2</td>
</tr>
<tr>
<td>Initiated by women – 3°</td>
<td>Not informed by a physician – 11b</td>
</tr>
<tr>
<td><strong>Mammogram:</strong> (total – 12°)</td>
<td><strong>Mammogram:</strong> (total – 11°)</td>
</tr>
<tr>
<td>Initiated by a physician – 6</td>
<td>Informed by a physician – 2</td>
</tr>
<tr>
<td>Initiated by women – 6°</td>
<td>Not informed by a physician – 9d</td>
</tr>
</tbody>
</table>

a. Excluding the women who initiated the tests because they had some concerns or symptoms (n = 3); b. Two of these women were not sure if they ever used a Pap-test but even if they did, they certainly did not receive information or explanation from their family doctors; c. Excluding the women who initiated the tests because they had some symptoms or family history (n = 4); d. Excluding the women under-40 years old who are not recommended for routine mammography (n = 4).

As the table shows, physicians initiated the preventative use of a Pap smear for the large majority of women. Only three out of 15 women who used a Pap smear at least once in Canada for preventative purpose initiated the process. Although more women initiated a mammogram than a Pap smear for themselves, half of the women using a mammogram received a recommendation from their family physicians. As a mammogram is not done by a family doctor in his or her office, it is reasonable that some women would take it in their own hands to arrange it for themselves, especially because no referral is required for women aged 40 and older. In contrast, if we consider the pattern of women’s lack of use of cancer screening, the table shows that an overwhelming the majority of the women were never recommended or informed by their physicians to have either a Pap smear or a mammogram. Only two women from each of the groups of women (13 and 11 for Pap smear and mammogram respectively) did not use the tests despite being recommended by their physicians.

A few women in the study mentioned having a clinical breast examination done by their family physicians. When I asked women whether their physicians were doing a clinical breast check-up during their general physical examination, only one woman in the South Asian women’s support group replied, “[Only] if I say there’s a problem, otherwise not!” Three women in the study mentioned being recommended and instructed by a physician to do a self-exam. One 46-year-old woman said she was instructed by her family doctor to do a self-exam while getting
her clinical breast exam, but she never practiced it or felt the need to do so. On the other hand, a young woman (34 years old) mentioned she was never asked or instructed by her family doctor to do a self-exam although she was getting clinical exams done by the doctor. Women’s experiences indicated that physicians were not equally pressing the issue of BSE, or practicing any standard method regarding CBE and BSE for all the women. By and large, most of the non-users of female cancer screening in the current study were not informed or recommended by their doctors to use these tests; a few women ignored the physician’s recommendation, but those who did, did so due to a complex interaction of several other factors such as, lack of time due to gendered work of homemaking and childcare, lack of perceived need due to lack of symptoms and presence of other priorities, among others. But most women who already had asked their physicians to perform or arrange these tests were not happy about their doctors being so passive regarding not only cancer screening, but also their overall health issues. While some women were informed and educated about these tests by their physicians, a number of women who did not know anything regarding the issue held their physicians responsible for not informing them. Jasmine, for example, exclaimed, “How do I know? My doctor never told me!” On the whole, women who were not using the tests because their doctors never informed or discussed the issue with them, along with women whose doctors were managing cancer screening for them, and even the women who were proactive in raising the issue to their doctors and initiating the tests—all shared a view that family physicians should be responsible for informing, initiating and regularly continuing these tests for women.

**Receiving Regular Reminders**

While physician recommendation was a vital factor for initiating cancer screening for women, a regular reminder about the due date of taking the next cancer screening tests was mentioned by a number of women as important for continuity and regular use of the services. In BC as in most of the provinces in Canada, breast screening is provided through organized breast screening programs and some of the benefits of this program include getting regular reminders of due dates for next screening and reports of the screening results being sent to family physicians and patients. All the women taking regular breast screening through mammograms mentioned receiving regular reminder notices from the special clinics and they were overall very pleased with that service. The South Asian support worker also mentioned, “They are very good. They
send you the letter after the exam and then they send you reminders. So it’s quite streamlined.”

As Chameli, one of the women in the support group, said, “They care a lot!” She further mentioned that even though she always received a written reminder about the due date of her next mammogram, once she was not able to make it to the clinic for some reason. Then the clinic staff called her more than once to follow up. So she asserted: “because they keep on sending the reminders I’ll keep getting it done!” Camellia also gave positive comments about her experience at the breast screening clinic, but as well critiqued the family physicians’ inactive role in initiating women’s cancer screening processes –

...what I did for the test [mammogram] after my doctor had sent me for doing the test – that part was good. The technicians that do these tests over there are pretty good. I didn’t find any fault with them. They were good and did everything quite well. They know how to handle a person and they have the sensibility needed to deal with a patient. But before starting that process, I’d say the doctors are not playing their parts properly in this regard.

Only a few women mentioned receiving regular reminders from their family physicians about the due date of their next Pap smear or annual general physical examination. Among the women who used Pap smears more than once, some women mentioned receiving reminders or calls from their doctor’s office about the next due date while others had to ask or remind their physicians. For example, Devi, a member of the South Asian support group, complained that she always had to remember and remind the doctor when the next Pap test was due –

Even myself, I have to ask the doctor. I don’t get any, like, letters that you have to have a Pap smear done. Only for the mammography I get letters. I just did my Pap smear few months ago. But no, I didn’t get any [reminder/letter]. Usually I just figure out and I just ask the doctor. Then he does it. So only if I ask the doctor he will do it otherwise he doesn’t do it.

The South Asian community support worker not only facilitated the group interview with the support group members through providing translation and interpretation help, but also shared her own health and medical experiences. She offered very important insights about many health related policies and especially about the nature of doctor-patient relationship in a neoliberal environment of self-care and self responsibility. Hearing the women’s stories in the group, she exclaimed,

You see, the message I can overhear is that most of us, we have to ask our doctors! THEN they do it otherwise they don’t do it at all ... yah, you know, that has been my experience too. Even I find that, even with my physician, I’m the one who has to ask my doctor’s secretary to book an appointment. You know, how many years ago, the doctors would call you and say, you know what – you’re due for your physical exam! You’re due for your check up. I don’t know, my
personal experience is – no longer are the doctors doing that! At least even my doctor, she’s not doing it. So I have to keep a track and then because there’s a history of cancer in my family, I want physical exams to be done every year. So I have to push my doctor otherwise she says, no, no, no, come every two years, right? So, that has been my experience.

Not all women, however, as already pointed out, had the knowledge, time or language and other skills to ask or remind their physicians about cancer screening, especially the elderly women without literacy who tended to depend on their family members and physicians for health information and medical decisions.

**Belief in the Importance of Cancer Screening and Reliance on Physician's Advice**

Both users and non-users of female cancer screening generally believed in the benefits and significance of cancer screening tests and more importantly, in the recommendation and lead of family physicians in this regard. Most of the women, who were not using any of the tests, along with some women who were using the tests, showed strong reliance on the advice of physicians. Many women believed that doctors know what is best for their health and if their doctors recommend something as important then they must do it. The same belief and reliance on physician advice also led some women, particularly the elderly ones with minimal or no literacy, to use the tests often without clear knowledge and understanding. Both the users and most of the non-users alike believed in the importance of cancer screening and the later group said they would definitely use it if their physicians ask them to do so. For example, Sidney, an elderly woman from Punjab of India, was using both tests because her doctor advised her although she did not have any literacy. She strongly believed, “There are definitely benefits [faida] of doing these [cancer screening tests].” She also believed, “Our family doctor tells us that everything needs to be checked. We don’t know, right!” But Dev, one of her friends cum neighbours with similar age and educational background, who was sitting and talking in the same group, was not using these because her physician never told her. She had many chronic and acute health conditions but even though she never felt any symptoms of female cancers, she realized, “It’s important, yes, you should do this. It’s free! It’s important to do these things, I know. But I’m tired of seeing doctors and keeping appointments. Sometimes the car is not working either.” Then her daughter, who was using both tests, said, “But you have to do these – go to the doctors, right? These are important!” Bela was regularly using Pap smears ever since she was diagnosed with a benign cyst in her uterus but she never had mammography done. However, she believed
that it is absolutely important for women to take care of their reproductive health. Similarly, Daisy, a young professional immigrant who used a mammography once but never a Pap smear in Canada, emphasized the value of cancer screening: “I think it’s good to get these diagnostic tests.” Thus educated or illiterate, recent or long time immigrant, young or old and user or non-user – almost all the women believed in the significance of cancer screening for a better health. But many of these women, sometimes despite a physician’s recommendation, were not using one or both of the cancer screening tests for various other constraints and systemic barriers to primary health care.

Many South Asian women, especially the elderly with minimum formal education, who depended on family members for finding and visiting a doctor and taking medical decisions, showed deep respect and dependence on their doctors. They seemed to view physicians as authoritative figures, and to take them very seriously. For example, when I asked Nargis, an elderly woman without basic literacy, if she would mind exposing herself to male physicians for examining her private body parts for preventing cancer even when she is not sick, she had a clear response: “If my doctor advises, if he writes then I’ll do, otherwise not.” These women’s perceptions about the importance of female cancer screening and their dependence on or respect for physician recommendation indicate that many South Asian women need or demand recommendation and education from their physicians about the importance of preventative use of these cancer screening tests.

**Access to Community Support and/or Community Service Agencies**

Support from community groups and agencies in the form of information about cancer prevention in South Asian languages and referral for such services was particularly useful for the women with lower level of education and English skills to get cancer screening done. In couple and group interview settings neighbours and friends sat together to talk about the issues related to cancer screening. It appeared they had never talked about these among themselves except the women in the first group interview. These women were part of a support group and were often informed and advised by their South Asian community worker to do regular cancer screening. All the three women who reported to have initiated a Pap-test for themselves in absence of any symptoms were members of this community support group. These women also initiated a
mammogram screening for themselves. Although most of the women in this South Asian support group did not have a high level of education and some did not have any literacy or English language skill, they had been educated about cancer screening and the importance of using the tests by the support worker in their own language. And this knowledge and support was one of the main reasons all of them were using one or both of the cancer screening services. When any of them had language problem or time constraint the support worker provided referral and helped with making appointments. For example, Preety, a 46 year old woman, did not know the English word ‘mammogram’ due to lack of English skill, but was aware of it and was able to get it done at the South Health Unit as referred by the support worker. Chameli, the only woman in the group who did not use a Pap test yet due to time constraints or preoccupation with other issues and failed attempts to make an appointment at the South Health Unit, was assured by the counsellor during the interview that she would make an appointment for her. All the other over-40 year-old women in the group were regularly using both Pap smears and mammograms. These women also had lived in Canada for more than 10 years; some of them for more than 20 years. Due to their adverse experiences of family violence, they already knew where to go and how to extract help, and they were also well connected among themselves and provided support for each other. Some of these women had even changed their family doctors to get better service; hence they were empowered and capable of demanding services such as Pap smear and mammography from their physicians. On the other hand, many new immigrants seemed to have experienced isolation and lack of support and services from immigrant service agencies. Some of the new immigrants, especially those who did not use cancer screening, did not even know about the existence of such services.

**Faith in God and Inevitability of Illnesses**

There was no clear dichotomy or conflict between women’s faith in God and their faith in modern biomedical practices including cancer screening. Some of the women, who were not using any of the tests, had much faith in God and in the power of prayer in keeping them healthy. But Dahlia, a user of both tests, also affirmed her strong belief in the power of prayer for good health and success in Canada. Women’s faith in God and inevitability of illnesses, however, appeared to be one of the factors contributing to a few women’s lack of use of cancer screening. For example, Gunj admitted that the issue of Pap smear never received sufficient importance in
her mind despite her physician’s advice because she believed, “everything is determined by the will of God (Allah) – if the almighty wishes everything can be alright but if ‘he’ wants, any illness can happen anytime no matter how careful a person is or how well she or her doctor takes care of her health.” She expressed doubts regarding the extent to which physicians can control these illnesses, especially regarding the power of biomedicine, which she believed, “...definitely cannot cure everything.” Often times, she depended on alternative medicine such as a naturopath and homeopath for herself or her family members for treating such conditions as a sore-throat and premature menstruation. As such she was not completely sure if these tests are that important at all. But she did not completely dismiss the idea of cancer screening and rather kept it as a postponed future agenda: “I think it would be better if I get it and I think I should get it done. I will.” So it seemed that because she could not afford using the cancer screening services currently due to time constraints and other priorities she rather used her belief in God as a defence hoping ‘He’ would take care of everything.

Some qualitative studies with South Asian immigrant women (Bottorff et al. 1998; Johnson et al. 1999) also described their belief in inevitability of suffering due to God’s will/act. Similarly, Kulbir’s daughter told me about her mother’s (Kulbir) strong trust in God [rab pe biswas]. Kulbir said, “I believe in God, and things [such as, cancer] happen, right? It’s in God’s hand. If something has to happen then that will happen.” In one couple interview setting, while talking about cancer screening, Mollika talked about her elderly neighbour, Nargis’ belief in God: “She always prays to God. She has much belief in God.” Nargis tended to believe that due to her good deeds and faith in God she would probably be protected from illnesses.12 None of these women, who believed in the inevitability of diseases as God’s will, were using any of the cancer screening tests. Unlike these women, Henna, an irregular user of a Pap smear test said, “I don’t believe in ‘whatever Allah desires will happen’ type of things! I’m not religiously superstitious.” But she did not strongly believe in the benefit of these cancer screening tests either, especially of the Pap smear: “...actually I don’t need it! We just go [to doctors] to do it

12 Both Kulbir and Nargis did not speak English or only spoke Punjabi. Kulbir had a diploma level education and some understanding of English but Nargis had no formal schooling and absolutely no English. Kulbir’s daughter provided translation and interpretation help while Nargis’s neighbour Mollika (a research participant herself), mostly spoke on her neighbour’s behalf. However, both women seemed to be quite used to such arrangements. A few times Nagis said, “Don’t ask me these questions. I don’t know about this!”

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unnecessarily!” When asked, “Why do you think it’s unnecessary?” she replied, “Probably I think that, actually I’m not getting sick in lack of this. When I’m really sick then I’m forced to go [to doctors]!” Henna’s comment reflected the issue of lack of perceived need of cancer screening also noticed among a few other women – an issue that intersected with many of the other factors including faith in God, and influenced women’s participation in secondary cancer prevention through regular screening.

Perceptions of Risk Factors and Need of Cancer Screening

Lack of perception about the need of cancer prevention has been widely reported in the literature as a cultural trend among South Asian women. For example, Gupta, Kumar and Stewart (2002) pointed out that cultural beliefs about ignoring preventative medicine may interfere with a South Asian woman’s access and utilization of health care. But for a number of women in the current study, the intersection of time constraints with other family or health priorities contributed to their perceived lack of need and influenced their lack of use of one or both cancer screening services. While some women initiated the process of cancer screening in absence of any symptoms because they strongly believed in the value of prevention, some women did not consider prevention because they did not think they needed it or were at risk of having any cancer. A lack of symptoms or any family history of breast and/or cervical cancers often contributed to their perceived lack of need for prevention. For example, despite her knowledge and experience of getting a Pap smear done in the US, Champa did not initiate the process in Canada because as a new immigrant she had other priorities, and more so because she did not have any immediate symptoms or needs –

*It is in my mind that it is important for women’s health to have the screening but maybe on my part I forgot or maybe I didn’t bother to go for Pap smear because I didn’t feel [the need] for myself, yah, that I have some problem ... that needs regular test for breast cancer or cervical cancer... To be very frank and honest...I will say that I have this impression that I don’t feel that I have this problem. Yah, that’s it.*

Similarly, Kulbir never used a mammogram or a Pap smear because she never felt the need for using these tests as she was very healthy and, in her daughter’s words, “She thought she had no trouble.” The daughter also commented on her mother’s health seeking behaviour: “You know, some women like to go to doctor for no reason! She’s not that kind of a person.” Kulbir’s doctor, a young Punjabi man, once mentioned to her that if she would like to get a Pap smear done she
could make an appointment with a “lady doctor” working in the same clinic. But being a very healthy woman and having no chronic health conditions she never felt the need of prevention of cancer screening. Another woman, Bela, never used a mammogram and she did not practice breast self-exam regularly despite being asked by her physician to do so because she did not feel the need –

I never feel sick or any kind of pain. Sometimes I do a little bit [breast self-exam], but not strictly according to the instructions, like following particular timing when you should check your breasts. But I don’t feel anything like that in my breast and I know that if there’s anything wrong or abnormal I’ll be able to feel it. But everything is normal so I’m okay ... So I don’t feel the need ... When I have the time or need then I’ll do it.

Some women’s perceived lack of need of cancer prevention through screening also depended on their level of awareness and knowledge about cancer, cancer prevention and especially the risk factors. Jasmine, an elderly woman with no formal schooling, did not have much knowledge of female cancers. She associated risk of breast cancer with her breast size. She thought she did not need a breast screening test because she did not have big breasts. When asked whether she ever checked her breasts, she said, “No lumps [gilty], nothing, I don’t need!”

Women who did not have a history of breast or cervical cancer in the family thought they might not be at risk. A few women even thought that their physicians did not talk to them about cancer screening because they never complained of any symptoms or problems. For example, Chameli, when asked if her family doctor ever suggested a Pap smear to her, had a negative reply: “Because I didn’t have any problem [taklif] at that point …!” She was used to her physician checking in only when she raised an issue. Devi also suspected that because her mother (Dev) never complained about any such symptoms her doctor never mentioned or initiated cancer screening for her.

In contrast to these women, Gulmohar was a strong believer in the value of preventative health measures and practiced a prevention focused ‘healthy lifestyle’ since childhood –

As a health care professional I have awareness – we’re aware of the healthy lifestyle ... I try to live in a way that is more focused on preventive care. I try to minimize everything, like, in course of the lifestyle practice – so that nothing happens – through what I eat and exercise or stress management, everything ... when we were quite young we practiced Indian traditional system of natural therapy, yoga – these kinds of things – as we grew up. We have books in our house on natural therapy and the traditional yoga system. So we used to practice these as a part of our culture right from our childhood.
As a very health conscious woman with a background in a health profession, she was the only one in the study to have used a mammogram test once in her country of origin for a general check-up and prevention of breast cancer because she knew, “I need a screening at my age.” Her knowledge and focus on preventative care also led her to initiate a mammogram after immigrating to Canada for the same purpose of prevention. Yet for some women managing other chronic health conditions was a greater priority or need. And the need of cancer prevention did not seem to be as important as taking care of other immediate health needs, particularly when women had to deal with time constraints and balance their unpaid gendered labour of parenting, childcare and housework with full time paid work. Gunj was recommended to have a Pap smear by her family physician. She believed that she did not need a Pap smear immediately because of time stress as well as a lack of priority: “I can do without it for now”. She always postponed it over other priorities and sidestepped it: “We’ll see later.” She was only doing whatever was absolutely essential, such as, taking medications to control hypertension. Bela also had other chronic health conditions that needed immediate attention and a child with special needs to take care of. Getting a mammogram was not in the list of her priorities –

_Bela: I still am so much preoccupied with my son’s needs and conditions that I haven’t still paid much attention to that side [mammogram]. And also, I’m especially more concerned about the joint pains and diabetes that I have ... I haven’t looked at that side yet. Even now if I have time I look into the Internet for stuff or info on diabetes or joint pains._

Simply speaking, these women’s narratives reflected their perceived lack of need of cancer prevention, but this was quite entangled with other issues such as, gendered roles, lack of time, competing priorities in the lives of many women as immigrants, who experienced isolation and lack of extended family support.

**Gender Roles and Time Constraints**

Much research has already shown that family and job responsibilities make it difficult for many immigrant women to use existing healthcare resources (Egan and Gardner 2004; Kinnon 1999; as reported in Mulvihill, Mailloux and Atkin 2001). In the current study it was found that the gendered labour of parenting, childcare and housework created time constraints for some women, especially those who had to balance it with full time paid work, and impacted such women’s use of cancer screening services. Lack of time is a special challenge for many South
Asian immigrant women because they lack the support of extended family members left behind in home countries. The time pressure due to paid and unpaid work in tandem with the tendency of women to put family before themselves due to social expectations hindered some women’s motivation or perception of preventative cancer screening as an immediate need or priority, especially in the absence of any symptoms or family history. All the three women who disregarded physician’s recommendation to have a Pap smear and/or mammogram were in their early to late 40s and were preoccupied with full time paid work as well as household and childcare work and received little to no support in this regard and often cared for elderly people in extended families. These women struggled to manage the time to take care of themselves or even to keep an appointment with their physicians. As Bela, who had a child with special needs, mentioned –

*I have to adjust to my work schedule and often I can’t make it to a specialist appointment due to work. Or, maybe I need to go for ultra-sound test or to a doctor but I have work at that time, or my son is at home and so I have to stay with him at home as there’s no one to take care of him at that time, then I have to cancel the appointment. In case of my family doctor’s appointment I still need to check all these stuff to see if I can make it. I have to make cancellations quite often or change the appointment.*

On the other hand, most of the elderly women participants in this study were not found to be pressured by lack of time or juggling with paid and unpaid works. The elderly women were either housewives or retired, and they usually provided extra hands in extended households with housework and cared for their grandchildren. They generally had sufficient leisure time for mingling within the community such as, going to temple or for a group walk with neighbours. Kulbir, a 62 year old retired primary school teacher from India, was the only exception. She mentioned being very active and primarily in charge of cooking, cleaning and taking care of her granddaughter in an extended family. She never used any cancer screening mainly because she never felt the need, but Kulbir’s daughter thought, “You know, part of it is time too. I guess, my mother still has too much responsibility. You know, she’s helping with the kids and [in] the house and all that … You’ll not see her sitting in the couch.”

**Fear or Stigma of Reproductive Cancer and Cancer Screening**

While the issue of understandings and attitudes about breast and/or cervical cancer often received disproportionate attention in the literature on South Asian women’s use or lack of use of
cancer screening tests, only a few women in the current study talked about this. Kulbir’s daughter, a practicing nurse in Canada, while helping with the translation/interpretation for the interview with her mother, shared her insights regarding lack of cancer screening among South Asian women –

*I know what they think. They are scared of finding something wrong – yes, they are! You’ll tell them and they’ll say – for my mom I can definitely say – she’s scared. She’ll say, oh there’s nothing wrong, why should I go? But I know that underlying [this denial] there’s a fear – what if there is something [wrong]? Yah, I’d know because knowing her, I can tell you, there’s one thing inside her. She’s scared inside... the name cancer, the name itself – people just may feel kind of scared, right?*

Kulbir seemed to agree with her daughter’s point about fear of abnormal test results as she shyly smiled and nodded. Upon further probing it appeared that she was also scared or rather anxious about the procedure of women’s cancer screening. Due to her lack of knowledge and exposure she did not know what to expect or exactly how the process goes. A few other women shared their feelings of discomfort and concerns about the cancer screening process because the tests involve touching the most private parts of the female body and appear to be intrusive and intimidating. But Kulbir was the only woman in the study to refer to the fear of cancer and the possible negative outcome of the cancer screening process.

The current research did not find the perception of cancer as stigmatizing to be common or prominent among the participants, either users or non-users. Mollika, a nurse from India and a non-user of any cancer screening, denied any fear of cancer. She said, thinking a bit, “If I will suffer then what can I do! [smiling] If there is some treatment then I can get treatment.” Poppy, a user of tests, strongly believed, “If one suspects any problem such as cancer, women should do a check-up and take early actions rather than worrying about it.” Malati, another user, thought that it is rather inauspicious to talk about cancer with friends or neighbours, but not so when talking to physicians. She believed this should be discussed with doctors because they can treat or take care of such problems. Her neighbour, Lily, an elderly woman with no literacy, was taking regular medications for hypertension and diabetes but never underwent cancer screening. She was more conscious or aware of these chronic health conditions rather than cancer, which was not as common as hypertension or diabetes or arthritis among her friends and neighbours. She often talked to her friends and neighbours about those illnesses but not about cancer. But she did not have any particular fear of, or negative attitudes towards, cancer.
Some of the participants thought that South Asian women usually do not openly talk about reproductive and sexual issues considered to be a taboo. For instance, Champa said, “In this country, every young girl knows [about sex and related issues] but back in home if you ask a girl who’s studying in a university, maybe she will not know that, you know! And they even don’t want to discuss these kinds of things, even to each other. They are shy.” Rose also agreed: “... mothers and sister-in-laws don’t talk about that type of things [breast or cervix] in front of girls who are not married. So I didn’t know anything about these [before getting married].” Mollika thought not every South Asian woman is shy but “religious Sikh old ladies are shy ... [they] wear the old [style] clothes, not deep neck shirts or things. They always cover their body. They don’t want to expose themselves … they don’t want to talk [about intimate body parts].” However, I found that women in this study were quite comfortable talking about breast and cervix/uterus when presented and perceived as a health issue. All women except one were married and all of them except one had at least one child. Thus these women had already had exposure to gynaecological procedures and were not shy to talk to me, a South Asian female researcher, about breast or cervical health issues. This seems to counter Gupta, Kumar and Stewart’s (2002) description that sexuality is a very sensitive and secretive topic in many ‘Eastern cultures,’ a topic unlikely to be discussed in homes or within small community settings, and their conclusion that this leads to significant obstacles to the use of sexually related health care services, including screening for cervical cancer.

**Experiences and Embarrassment of Undergoing Sensitive Physical Examinations**

Little is known about South Asian immigrant women’s experiences with cancer screening services and the quality of services they receive and whether and how their experiences or the quality of such services impact their regular use or lack of use. I asked women who were using mammogram screening about their experience with the service and their thoughts and feelings about the screening process. But such questions usually did not elicit an elaborate response. Women mostly gave very brief answers such as, “it was all right!” or “it’s okay.” A few women, however, talked about the unpleasant process of cancer screening, and a few women described the process as embarrassing. Deepa said, “... They press your breasts very hard!” Malati smiled shyly and said, “The machine presses the breast very hard. That’s very hard (akhha)!” Although Ivy did not use a mammogram test in Canada she described her unpleasant experience of using it
in India. Unlike most other women she was very frank and articulate to express her feelings about it –

Ivy: ... my experience was horrible! Because I don’t have a big bust of course! So they just pull it and squeeze and put it in these two plates and press this you know! So it’s like a –

Interviewer: it’s not a pleasant experience at all!

Ivy: Absolutely not! Absolutely! Maybe a person who has a bigger bust, it’s easier for her. Because with my bust, you know, they really had to pull my skin out! So it was so painful and it pulls your whole busts out of your body, you know, when they did [it] in Calcutta [India]. So I, I’d rather not do it even if I’ve been asked because I’m so scared! It’s so painful! ... I was so scared of the pain, you know, I thought oh my god! I won’t do it again, I screamed! I literally screamed and then I thought no, let me have even cancer, I don’t care anymore [laughing] because it’s very, very painful.

However, despite her unpleasant and painful experience, she said she would use mammography again: “Probably yah, I suppose! I have no other choice!” Bela, a regular user of Pap smear said, “If I had a choice not to do it I’d not go for it!” As she expressed her feelings about the test –

[I feel] awful! In one word, awful! ... Doctors are very helpful. But as a person, I have this personal problem that I don’t feel easy or I have trouble feeling relaxed during the process. But except that, they are very helpful because they are experienced. They know very well how to do it and how to deal with the patients. But because I can’t feel relaxed during the process I feel bad! But regarding the service provider’s attitude or procedure – they are very professional and they don’t do anything bad.

Henna, a well educated woman, used the Pap smear a couple of times irregularly in Canada. Throughout the interview conversation Henna was trying to explore and understand herself as much as I was trying to understand what influences her lack of regular use of a Pap smear or mammogram in spite of her doctor’s recommendation. At one point, she expressed her disgust and embarrassment of the cancer screening procedure: “I’d like to avoid that [Pap-test]. That bothers me a bit. Even the process of mammogram – I don’t like that as well, that I have to expose myself [laughing shyly] – I’m not comfortable, right!” But she opposed her own comment in her next statement: “But that’s not a big deal really because a male doctor delivered my baby here in Canada. Even back home I had a male gynaecologist who delivered my two other babies. So, the process itself or the gender of the doctor is not a big deal. But, I don’t know...!” When I wondered if prevention of illnesses was not important to her she said, “I know prevention is important but I don’t like to go to doctors [for Pap smear or mammogram]!” It seemed that the testing procedure might cause a little uneasiness for her but it intersected with
other factors such as, lack of perceived need of prevention, especially in lack of any symptoms or risk factors. She also mentioned time pressure caused by her double duty of paid and unpaid work in her home daycare and lack of childcare as barriers to using services for prevention of reproductive cancer. As such, this issue of embarrassment appeared to be quite intricate and entangled with other barriers or influences.

While some women talked about the discomfort of the cancer screening procedure some women also thought it was necessary for the sake of maintaining good health, particularly those who seemed to be more convinced about the value and need of cancer screening for preventing fatal illnesses. In contrast to most of the users of mammogram, Juhi, who did mammograms a couple of times, had a positive experience and opinion about the test. When asked if she had any discomfort or pain, Juhi asserted, “No, no, nothing! Yah, because at work, at the office, they put a paper [notice] about mammogram, and a lady asked me, is it painful? I said, no! It’s not painful, yah!” Juhi also shared her favourable experience at the breast screening clinic: “I went for mammogram and they treated me very good.” She thought that even though the processes of mammogram as well as Pap smear are quite invasive and intrusive into women’s private body parts it has to be tolerated and done for the sake of maintaining good health as she said, “What can we do? We have no choice.” Another woman, Malati, was also quite practical in this regard: “I feel some, a little bit hesitation and uneasiness. But it’s okay. It’s for our own good!” Thus despite the embarrassment and discomfort most users were using one or both cancer screening services because they believed in the importance and need of these tests for an early diagnosis and prevention of reproductive cancers.

**Gender, Age and Ethnicity of Physicians: ‘A Doctor is a Doctor, Right?’**

Despite the fact that most women in the current study were getting a cancer screening done by a female physician and that a majority of the women who did not use cancer screening had a male family doctor, none of the non-users mentioned physician’s gender as a barrier to their use of the Pap smear or mammogram test. Thirteen out of 31 participants had a male physician, whereas seven out of eight women, who never used any cancer screening, had a male family doctor. One of the two women who were not sure of their use of a Pap smear also had a male family doctor. However, having a female physician or a physician of the same ethnicity and language spoken
did not ensure recommendation or initiation of cancer screening for a number of women. Women’s experiences unpacked the complexities and nuances of the intersections of physicians’ gender, age and ethnicity and their impact on women’s use or lack of use of cancer screening. Physician practices and recommendations appeared to be much more important than the gender or ethnicity of the physician. Despite women’s greater preference for a female physician, especially for female cancer screening, women who lacked cancer screening and had a male physician viewed their physicians as a health expert who can heal and take care of their wellbeing rather than as a ‘man’ [adm]. The non-users of cancer screening, rather than pointing to the gender of their physician, indicated that the physicians never recommended or informed them about the importance of prevention of cancer through these tests.

In general, South Asian women’s expressed preference for a female healthcare provider, especially for a Pap test, has been well reported (Ahmad, Gupta, Rawlins and Stewart 2002; Oelke and Vollman 2007). Women’s preference for and comfort with a physician of a particular gender in the present study was also influenced by the age and/or ethnic background of the physician and more importantly, by the physician practices. While all the women had a mammogram done by a female technician or physician, five out of 18 women who used a Pap smear at least once in Canada had it done by a male physician or gynaecologist. And one woman had clinical breast exams done by a male physician. Devi was quite comfortable with her male physician because “He always asks me that – are you comfortable with me doing it alone? If not, then I will ask one of the secretaries to be present in the room.” Juhi mentioned she did not have any problem getting her Pap smear done from a male doctor. She mentioned that her doctor often did a clinical breast exam and she had no concern regarding that because –

*Mostly one thing I like [about] my family doctor – whenever he checks my breasts, he always closes his eyes! Always, he closes his eyes, yah! He never looks at you face to face. He always closes his eyes, yah! And he’s [a]very nice doctor. And I don’t want to lose him. Because he knows me for long time, he understands and then I never hide anything from him.*

On the other hand, Bimla did not feel comfortable to have a Pap test from her male family doctor of her own ethnicity because he was charged with some misconduct. She said she was more comfortable doing Pap smears with her male gynaecologist because, “He is not [an] Indian! He’s from a Chinese background.” Salina had known her elderly male family doctor for a long time and her children were delivered by him and thus she became somewhat comfortable
with him. But she thought, “A female doctor is different than a male doctor” because “if it’s a male doctor they don’t really want to [talk], you know, sometimes they give you a brochure if you know English. And you read brochure, they will bring you some more, yah!” Kasturi also thought the quality of cancer screening service varied with the gender of the caregiver. She regularly went to a clinic where a South Asian couple practiced as physicians and she was lucky to have both of them as her doctor. Although she had Pap tests done by both of them and both provided “excellent service,” she admitted, “I didn’t feel quite comfortable with the male doctor but I feel more comfortable with the lady doctor. I think, I feel more comfortable because you can share things better with a lady doctor than with a man, just as a woman.” But she thought it would be very rude to express her intention or preference to get a Pap test done by the female doctor, or even to ask the male doctor not to do it because “The man would think, why? He’s also a good doctor, right! I feel like, it’s not good.” She decided to strategically pick the time for an appointment for a Pap test when the female physician would be available. Daisy, a highly educated woman, who never had a Pap smear done in Canada, rather spoke straightforwardly about her preference for a female doctor for getting a Pap-test –

_I don’t feel comfortable with a man even though they’re doctors or whatever! I don’t like it when man [does this test] – you feel, you feel – well in England once [I did it with a male physician] but he was my GP [General Physician], my close GP so he did my physical test. Yah, but I knew him for a long time and there was a female nurse._

Thus these women’s preference and level of comfort with a physician depended on the physicians’ age, gender, ethnicity, practices (showing empathy, sensibility, listening and attending to women’s concerns) and long-standing relationships with the women.

A number of participants went to the ‘South Health Clinic’ for cancer screening because they have Punjabi speaking female staff. Dahlia, a woman from Pakistan had a male doctor of Chinese origin who informed her about mammography and Pap smear, and sent her to the special clinic where her mammogram and Pap smear were performed by a South Asian female physician. She eventually changed her male doctor and chose this South Asian female doctor as her regular family physician because of her increased level of comfort with the female physician. Preety from the South Asian support group also mentioned changing her previous male family doctor for the same South Asian female doctor. The South Asian support worker explained the reason on her behalf:
When Preety had a male physician, he never recommended her [to the South Asian lady doctor at the South Health Unit] but when she had started to come to see me, then I had recommended to her. So she has started to get it done at South Health Unit. And now she became her present physician, she does it. So she says the doctor explains to me that okay, I’m going to first examine your breast and then I’m going to put this spatula inside you and then I’m going to scrape a tissue and all that. So she says that the doctor is very detail in explaining to me. So she says, now that’s how she gets it done.

A few women from a small South Asian community brought up the issue of comfort, privacy and personal space when it came to seeing a doctor, often irrespective of a male or female, from within their ethnic community. For instance, right after coming to Canada, Camellia started going to a relatively young male doctor of her own ethnic background. But when she realized that she would have to do Pap smears and gynaecological tests she thought she would not feel comfortable getting those done by a man from the same community. For Camellia, gender of a physician was rather subsidiary to the issue of age and ethnicity of a physician. She did not necessarily have a problem with a male doctor but she could not imagine seeing a male doctor of her own ethnicity, more so because he was also close to her own age. As she stated –

I wouldn’t probably mind to do it with a Caucasian man or someone from outside our community. But he is from my country and he is also young! I figured out he was only one year senior to me. So I thought I would not see him anymore. So I started looking for another doctor and then a friend recommended her doctor. Then I got her address from the friend and went to see her.

The man was viewed as too much of an insider by Camellia and his age probably challenged her level of comfort and the kind of distance or space needed to view a doctor as a serious professional and respected person, especially when examination of the most private body parts is involved. So Camellia changed her doctor not because of his gender but his age and ethnicity. On the other hand, Bela, like many other women, thought that her Pap-test should be done by a woman: “Because I’m a woman I’d prefer that it is done by a woman.” But interestingly, she never went to her family doctor, a South Asian woman, for a Pap-test since that involved too much intrusion into her privacy, even though by another woman –

I wanted to do this with another doctor ... because I didn’t feel easy [even] with a woman! Because if I went to her for the test – I would have to continue going to her regularly [for other health problems] – I wouldn’t feel comfortable anymore! ... When there’s an issue of ‘too much privacy’ then you think, how would I come back or meet her again! There is an uneasiness involved because then I think, this woman knows me inside out! Even though she is a doctor, but
still I feel an uneasiness or discomfort. Many other people may not feel the same but I do ... I’d rather go to a different doctor who I don’t see throughout the year.

In fact, Bela was not the only one; Henna also shared a similar attitude or concern. Although Henna did not have a strict reservation about seeing a male doctor, it was the same issue of perceived threat of violation of privacy and feeling of discomfort that bothered her when visiting a male doctor in her community –

_Henna: ... I only had one very uncomfortable situation once when I went to a heart specialist in our community here. He does the ECG himself so I felt very uncomfortable._

**Interviewer:** would you please explain why?

_Henna: I felt like, oh my God! He’s like my brother whom I’ll probably meet somewhere tomorrow. You understand?_

**Interviewer:** o-h! He’s too familiar, like a family member.

_Henna: yes, he is like a relative, right! But I didn’t have any problem with the male gynaecologist back home. But suppose, your husband, if he’s a doctor, I’m not comfortable to see him. Okay? I’m not ready to do gynaecological test with him. Because he’s a friend’s husband, okay? I have objection here. But if he’s somebody else who I don’t see quite often –

**Interviewer:** you just see him as a professional, that’s it! But it’s like somebody else you know –

_Henna: yes, because I’ll probably meet him tomorrow again. I’m uncomfortable there. It may be our ‘Bangali mentality.’"\(^\text{13}\)

This may not be actually a ‘Bangali mentality’ but rather a problem of a small community where almost everybody knows everybody, where it is hard for a patient to view a doctor simply as a professional or distant person when he or she is a friend or familiar person and vice versa.\(^\text{14}\) Oelke and Vollman (2007) also mentioned lack of trust, confidentiality and a dearth of acceptable health practitioners within a small and close-knit Sikh community as a barrier to cervical cancer screening. However, Henna also pointed out that this is not only a women’s problem. Just as a woman may feel uncomfortable with a man of her own small community

\(^\text{13}\) Bangali is a common alternative term for Bangladeshi although it denotes more of a language based ethnic identity than a nationality. The language Bangla is also commonly spoken by the people of West Bengal of India and as such the Bangali identity is shared by those Bangla speaking people as well.

\(^\text{14}\) As already stated in the methodology chapter, this might be the same reason I failed to attract more diverse women from my own ethnic community. As an insider I might have threatened their sense of privacy and personal space.
checking her body, it’s also a problem for a man when a close female member of his community has to do a medical check up of his private body. As she gave an example –

... when my husband became 50 I reminded my doctor twice or thrice to do a thorough check-up for him. You know, men often have prostate gland problem, right! So, I asked our family doctor to check my husband’s prostate gland. Now we had the same problem here because my husband wouldn’t do a check up with her. And my doctor also wouldn’t like to check my husband. She also said, I’m not comfortable to see your husband. So, there’s a male doctor, also from our community, who practices at the same clinic. So, our lady family doctor asked my husband to do the prostate gland test with that male doctor on a Saturday. But my husband didn’t have the time yet.

Thus the issue of privacy seemed to further complicate the question of gender preference among South Asian women already compounded by other factors such as, race/ethnicity and age of the physician. Overall, most women, irrespective of their age, class, educational qualification, religious and rural/urban backgrounds, showed preference for female physicians, especially for gynaecological and cancer screening purposes. For example, Gunj said she would not bother about the gender of her dentist but would definitely want a female doctor in case of a gynaecological need, such as a Pap test. So her gender preference depended on the kind of health care need or symptoms. Henna chose a female family doctor “so that she [doctor] can do more personal tests if needed.” But she also showed a somewhat flexible or indifferent attitude toward the gender of a doctor because she had all her babies delivered by male physicians: “Yes, a doctor is a doctor!” Five out of seven Pakistani women, however, expressed a stronger gender preference for their physicians. For example, Rose had a graduate degree and fluency in English, and she maintained that when choosing a physician, “We always look for ladies”. Her friend Zinnia had a language issue on top of the gender issue, so she looked for a female physician who could speak her language. She mentioned the problem she faced because of the gender preference: “Where I go, there are usually male doctors at that place, right? But we don’t want to see male doctors …when my doctor was on leave there was a male doctor at her place. And until she was back I couldn’t make an appointment.” Another Punjabi speaking Pakistani woman, Malati, rationalized the gender preference: “We prefer lady doctor because sometimes a lady may have internal problem or something – that’s why we don’t want to express them to a man.” Her daughter-in-law, who also had the same family doctor, mentioned, “Sometimes if our family doctor is not there then there’s another white lady and she attends her [mother-in-law].” Three Muslim women from Pakistan talked about religious or cultural restrictions to see a male doctor.
Rose said, “It’s a religion thing. It’s our culture you know … I mean, we’re not, like, supposed to expose ourselves to strangers, right?” But she and her friends also believed that staying alive is more important and Islam as a religion gives permission to do anything necessary to save a life. They maintained that it is allowed to see a male doctor in a life-threatening situation but they needed husband’s permission, as the following conversation reveals –

Zinnia: but our religion also says that if you are sick and your life is endangered you have to see a doctor, doesn’t matter male or female. A doctor is a doctor, right? He is different from all the other common men ... In life threatening situations you must see a doctor. We take permission but my husband has told me that it’s okay! Yes, if we get female doctors, we’ll see a female doctor but if they are not available then it’s better to see a male doctor than seeing none.

Rose: yes, it’s an emergency, helpless situation [majburi] ... I always try to see a female doctor but once I had to take permission from my husband to see a male doctor in the emergency.

Poppy: my husband also told me that I should see a female doctor but if unavailable I can see a male doctor.

Thus rather than a ‘man’ the physician was perceived by these women as someone who can heal and treat the symptoms and save lives. They also echoed Henna and Ivy’s comment: “A doctor is a doctor!” This clearly shows that these women were more concerned about health than shyness or certain cultural or health beliefs, and challenges common stereotypes about Muslim women. Some other Muslim women in the study were quite flexible about the gender issue and no other Muslim participants mentioned the issue of asking permission from their husbands to see a male doctor. Juhi, a Muslim woman with little literacy, rationalized her use of a Pap smear from a male doctor:

You know, they are doctor! They save our lives – doesn’t matter male! What are we gonna hide? Because when we have baby mostly men doctor [are] there too! If sometimes you have labour pain, if [there’s] no lady doctor, then what you’re gonna do! If you wait for lady doctor something can happen, right! Yah! ... if I’m very sick I go hospital. If this lady doctor not there, if male, if I wait for lady doctor something can happen! Then why not? It’s a doctor, right? [It] doesn’t matter male or female.

The most indifferent or rather ‘professional’ attitude toward a physician’s gender was articulated by Ivy, the only participant of Sri Lankan origin, who considered herself “different from lots of Asian people when they go to a doctor.” As she insisted –

My mom was a medical person, okay? She was a gynaecologist, diploma gynaecologist. So my mom used to always teach us that wherever you go to a doctor you need to be very professional. You need to really tell the truth to get the right treatment. So for me, it doesn’t matter whether a doctor is a X or Y or what. I talk to the point and I talk about my business. I don’t ask for
sympathy. I want cure. If they say you have to now undress or I want to check your chest, I will
do it, whereas there are so many people who will be shy and will not do [it]. But my demand is, I
have come to you with a disease or problem, you have to cure me. And whatever is required for
that I’ll cooperate with you.

In summary, the South Asian women in the study had different attitudes and preferences
about the gender of their physician, although most showed preference for a female physician for
gynaecological purposes. But most of the women, who were not using cancer screening and had
a male doctor, indicated that they would have done it if their doctors informed and advised them.
Mollika, a nurse from India affirmed, “If I have to do a check up I’ll definitely do it. I won’t feel
shy!” She also claimed that Nargis, her elderly neighbour, would not feel shy either, and she
asked her to confirm the claim: “Aunty, when you had to do the [open heart] bypass surgery then
you had to expose your chest to the doctors, right?” Nargis replied, “Yes, hmm, hmm.” Then she
said, “Tell her [interviewer] that I feel shy. But if there is really a problem then I won’t. When
I’m sick then I have to go to the doctor.” Both Mollika and Nargis had male physicians. Only
one elderly Muslim woman from Pakistan, Lily, had a non-South Asian male physician at the
time of interview. She expressed her intension to change and get a female doctor not simply
because he was a man but did not speak her language either. So she felt getting a female doctor
with whom she could communicate in her own language and be comfortable talking about
female cancer screening issues would rather facilitate her use of cancer screening in future. To
the contrary, Jasmine, an elderly Sikh Punjabi woman, did not want to change her male doctor
for a female one even though he never informed her about breast or cervical cancer screening.
When asked if she would feel hesitation or embarrassment to get her breasts or cervix checked
by her male doctor she confidently said, “No, no, he’s all right. He’s a doctor – then no
problem!” But both of these women along with a couple of other women who used the tests,
thought their physicians might not have discussed the issue with them because they were male
doctors. In other words, they suggested that their doctors might have felt uncomfortable or
assumed the women would feel uncomfortable talking about female cancer issues. Dev and a few
other non-users thought that a lack of any symptom could be another reason their male doctors
did not discuss cancer screening with them.
Understanding the Complexities of South Asian Women’s Participation in Cancer Screening

One of the main objectives of my research was to know the nature and extent of women’s participation in breast and cervical cancer screening processes in the current sample. Among the South Asian immigrant women who participated in the current study, there were more women who were using both Pap smears and mammograms than women who were using neither of these tests. But there were fewer users of CBE and BSE compared to the users of Pap smears and mammograms. Most of the younger women were using at least one of these cancer screening tests – the Pap smear for which they were eligible. Elderly women, whose family physicians were managing their use, were using both tests whereas elderly women who were not managed by their physicians used neither. Recent immigrants and elderly women with limited or no education were among the majority of the non-users of the services. However, another very important research objective was to explore the influences that shaped these women’s varied levels of participation in cancer screening processes. Several intersecting determinants were identified to have facilitated and/or constrained the different levels of South Asian women’s participation in breast and/or cervical cancer prevention and detection processes. Those included women’s level of education/literacy, English proficiency and knowledge about cancer screening tests, length of stay in Canada, level of involvement in community activities and organizations, childcare and household responsibilities, presence or absence of symptoms or concerning signs and/or family history, faith in God and compliance to physician’s advice. Women’s participation in clinical and self breast check-ups seemed to be shaped by the same factors that shaped their use or lack of use of mammograms and/or Pap smears, although detailed data regarding these issues was limited.

One of the major influences on women’s different levels of utilization of Pap smear and mammogram was their understandings and knowledge about these tests, which were related to their age, generation, education, class and rural/urban backgrounds, symptoms or family history of breast/cervical cancers, community involvement and length of residency since migration to Canada. Compared to younger and more educated women, older women from rural Punjab of India and Pakistan had no literacy and no knowledge of Pap smear or mammogram unless they were educated by their physicians or community resource people. A number of studies have reported limited or minimal knowledge about Pap test and mammogram among South Asian
immigrant women, and this lack of knowledge has been associated with their limited or lack of use of breast and cervical cancer detection practices (Choudhry, Srivastava and Fitch 1998; Bottorff et al. 1998; Bottorff et al. 2001; Gupta, Kumar and Stewart 2002; Johnson et al. 1999). However, data from the current study demonstrated that the knowledge factor intersected in complex ways with various other factors such as, women’s age and generation, level of education, length of stay in Canada, participation in community workshops and support groups, in influencing women’s actual utilization of cancer screening services. Almost half of all the women (five out of 11) who never used a Pap smear in Canada were recent immigrants, most of whom had knowledge about these tests. Thus women’s shorter length of stay since immigration or, status as recent immigrants impacted their lack of use of cancer screening services. This is consistent with the results of quantitative studies that found a markedly lower use of Pap smear testing among recent immigrant women, especially among those of Chinese, South Asian and other Asian backgrounds (Lofters, Moineddin, Hwang and Glazier 2010; McDonald and Kennedy 2007; Woltman and Newbold 2007).

While some women had initiated the process of cancer screening because they had some symptoms or family history of female cancer(s), others had raised the issue to their physicians because they had proper knowledge and strong belief in the value of prevention. Yet some women were using these services often without clear knowledge because their physicians had initiated the process, and they, along with some non-users, believed in the importance of showing compliance to doctor’s recommendations. Most women who did not receive information or recommendations from physicians were willing to use cancer screening if their physicians would ask them to do so. The perceived importance of physician recommendation appeared to be one of the major influences on women’s use as well as lack of use of cancer screening in this study. Choudhry (1998) also noted that there was a heavy reliance on doctors for information and guidance among South Asian women because of the respect that these women have for their physician’s advice. However, a few women disregarded their physicians’ advice and did not use one or both of these tests due to the intersections of their personal understandings, beliefs and values and various interconnected barriers to accessing health care in Canada, such as, lack of childcare, transportation and access to community resources and support, and lack of literacy and/or familiarity with the healthcare system.
A lack of perceived need of prevention due to lack of symptoms related to breast or cervical health among women who were otherwise healthy partly explained why these women were not getting regular preventative cancer screening done. Not having any symptoms or family history as well as not having the proper knowledge led some women to ignore or not to discuss the issue of cancer screening with their physicians while women who experienced some concerns had no choice other than raising the issue to their doctors. Several studies (Bottorff et al. 1998; Choudhry, Srivastava and Fitch 1998; Johnson et al., 1999) found that South Asian women tended to seek advice from health professionals or engage in breast screening practices only if they had a symptom or were particularly worried. According to the observations of Bottorff et al. (2001), participation in screening in the absence of symptoms does not quite fit with South Asian women’s holistic views of health and health promotion. Thus this is often explained as a cultural belief or an attitudinal issue in the literature and what is often ignored is that the structural and material conditions of many South Asian immigrant women’s lives do not allow them to be concerned about prevention of potential diseases. Some women had low perception about the need of cancer prevention, but this was quite complicated by other issues such as gendered roles, lack of time, competing priorities in the lives of many women as new immigrants who experienced isolation and lack of extended family support.

No major cultural health belief seemed to have exclusively facilitated or hindered women’s use of cancer screening in the current study; rather some women expressed different personal health beliefs which in combination with other structural factors seemed to impact their participation in cancer screening. Some studies (Choudhry et al. 1998; Johnson et al. 1999) noted many South Asian women’s strong beliefs about cancer as a stigmatizing, painful, and untreatable disease, and Bottorff et al. (2001) observed that such beliefs deter the women from participating in cancer screening making it difficult for them to readily accept healthcare professionals’ concerns about early detection of cervical cancer. But such health beliefs or attitudes were not noticeable among the current research participants. Also, fears and anxiety of potential diagnosis of cancer, perceptions of breast cancer as stigmatizing and as a death sentence have been cited as important determinants impeding South Asian and other ethnic minority immigrant and refugee women from discussing the issue of breast cancer, and accessing mammograms (Bottorff et al. 2001; Women’s Health in Women’s Hands Community Health Centre 2003). But only one woman in the present study talked about such fear of cancer and the
cancer screening process. However, a few women shared their feelings of discomfort and concerns about the unpleasant process of cancer screening although most of these women also thought the discomfort or embarrassment of going through cancer screening was necessary for the sake of maintaining good health. This is congruent with the findings of a study that reported that some South Asian women thought that Pap testing was beneficial as a way to “keep healthy” (Bottorff et al. 2001). Data from the current study supported Choudhry’s (1998) observation that despite South Asian women’s tremendous faith in God as controlling their destiny, they showed acceptance of biomedical information, particularly when learned from interaction with others rather than from printed material or other media. In the current research, almost all the women, irrespective of their use or lack of use, more or less believed in the benefits and importance of cancer screening; but they also believed that physicians should play a more proactive and leading role in instigating this process. Thus beliefs about and attitudes toward cancer screening did not necessarily diverge between users and non-users of cancer screening tests. Even though only one woman in the study mentioned a fear of potential diagnosis of cancer, this nevertheless, reiterates the responsibility of care providers to discuss the issue sensibly and carefully with women, and to explain the purpose and procedure of the cancer screening tests for healthy women without symptoms.

While women put enormous importance on physician’s advice and on showing compliance with such advice, they did not consistently receive doctor’s recommendations about cancer screening. Although all the women except two recent immigrants had a family physician, the physicians played different roles in terms of initiating women’s cancer screening. As already shown in Table 4.6, most of the women who were not using cancer screening were not informed or asked by their physicians to do so. Most of the women who were not using cancer screening, and had a family physician who did not initiate the tests, were not educated and knowledgeable about the cancer screening issues. Therefore, they were not in a position to ask their physicians to initiate cancer screening. Many of the highly educated and professional women with the knowledge of cancer prevention were recent immigrants and they did not have familiarity or much exposure with the Canadian healthcare systems, especially the cancer screening services. Therefore they could not use those services. Physician recommendation has also been found in a number of studies to be the primary predictor of regular participation in mammography screening and to be more important than socioeconomic factors in influencing regular
participation in mammography screening (Johnson et al. 1996; Bryant, Browne, Barton and Zumbo 2002). Such recommendations for Pap testing have also been found to be highly significant in ensuring South Asian women’s participation in cervical cancer screening (Choudhry, Srivastava and Fitch 1998; Johnson et al. 1999; Oelke and Vollman 2007). In context of the current study, not being informed or recommended by a physician seemed to be as important as the issue of not knowing about cancer screening in influencing utilization. In fact, many women said they expected to know or learn about these health issues from their doctors. Even many women who were knowledgeable about these tests still expected their physicians to start the conversation and process of cancer screening. This is consistent with the findings of Oelke and Vollman’s (2007) study with Sikh immigrant women. The researchers found that although many participants felt that informing them about Pap test was the responsibility of the doctors, they had not been made aware of the test and its importance by their family physician. Oelke and Vollman reported that participants felt that some Punjabi-speaking physicians did not take enough time with women, who therefore did not receive the information or have a Pap test. Similarly, a community-based research with 214 immigrant and refugee women from the Caribbean, Africa, South Asia and Spanish-speaking communities found that doctors were not informing young women of color about breast cancer but rather only about STDs and pregnancy (Women’s Health in Women’s Hands Community Health Centre 2003). Despite the importance of recommendation by physician, Bottorff et al. (2001) reported that South Asian women do not consistently receive a physician’s recommendation for cancer screening. This problem was also detected in the current study. Although a lack of knowledge or literacy did not hinder some elderly women’s use of these tests because their physicians took the lead on this, some elderly women without literacy as well as most new immigrants did not use any of these tests mainly because their doctors did not guide them properly.

There are ample studies that indicated South Asian women’s preference for and comfort with female physician for conducting reproductive cancer screening (Bottorff et al. 2001; Grewal, Bottorff and Balneaves 2004; Oelke and Vollman 2007). The current study also noticed similar trends, but with layers of complexities, diversities and nuances of the issues. Although most women expressed their preference for and comfort of having reproductive cancer screening from a female physician, some women had more flexibility or indifferent attitudes about the gender of their physicians. Some women were getting Pap smears and clinical breast exams done
by male physicians and did not have any complaints. Most of the non-users of cancer screening who had male physicians did not feel that having a male physician was a barrier to getting cancer screening. They rather emphasized a lack of physician recommendation as the reason for their lack of knowledge and lack of use of cancer screening. Consistent with the findings of Bottorff et al. (2001), having a South Asian physician who could speak South Asian language did not guarantee a recommendation or initiation of cancer screening for all the women. Lofters, Moineddin, Hwang and Glazier (2011) rather noted that having a doctor of the same ethnicity was associated with lower rates of cervical cancer screening among South Asian and other ethnic minority women. South Asian women in Bottorff et al.’s study (2001) reported feeling uncomfortable and shy discussing Pap testing, particularly with male physicians with whom they had developed long-standing relationships. Some women in the current study mentioned that their sense of privacy as well as comfort was threatened by the possibility of visiting a physician of their own ethnicity or community, often irrespective of the gender, for tests involving touching of intimate body parts. Moreover, having a female physician irrespective of ethnic background did not ensure having cancer screening for all women either. In the end, physician practice and recommendation appeared to be much more important than the gender or ethnicity of the physician.

Most of the women who had a male physician were not informed about the tests by their physicians. This could indicate that probably the physicians were trying to be too ‘culturally sensitive’ holding essentialist or stereotypical cultural assumptions about these women’s shyness or lack of comfort about this topic. In fact, a few women thought that their South Asian or Asian male doctors might have felt hesitation or embarrassment to talk to them regarding female cancer screening. But exploration of this issue was outside the scope of the current project. Since this study only focused on women’s standpoints it was not possible to understand the problem from the physicians’ or healthcare providers’ perspectives. Perhaps some doctors tried to explain the issue of cancer screening but some women might not have paid much attention or they were not educated enough to understand these biomedical terminologies. Some physicians might have assumed as well that these terminologies were too difficult for the women to understand and simply avoided explaining. The class differences between physicians and women may also make such communication difficult. Moreover, healthcare providers may not be completely free from certain cultural beliefs and stereotypes, or may have personal level of comfort with people of
certain gender, age and race/ethnicity. There is a possibility that South Asian (male) family doctors may become overly conscious and sensitive about cultural stereotypes and feel uncomfortable discussing such issues with the women. For example, Grewal, Bottorff and Balneaves (2004) found in their study with South Asian women that some of the women’s male family physicians who recognized and appreciated the women’s discomfort with issues like Pap testing also avoided these topics. Oelke and Vollman (2007) also noted that while many Sikh Indian women found it difficult to ask a physician, whether male or female, for a Pap test, some Punjabi-speaking Indian doctors were themselves uncomfortable talking to women from their own community about Pap tests. Furthermore, Donnelly’s (2008) study examined the challenges in delivering breast and cervical cancer screening services to Vietnamese Canadian women from the perspectives of healthcare providers. Her qualitative study identified Vietnamese physicians’ cultural awareness of the women’s cultural beliefs and values about private body as one of the challenges. She reported that several male physicians acknowledged a feeling of uneasiness in providing information and discussing health care related to breast and cervical screening with Vietnamese women.

To conclude, women’s utilization of cancer screening or a lack thereof was not simply a matter of their individual attitudes or cultural health beliefs, which are neither static nor homogenous in anyway. There was no unique South Asian cultural health belief or practice that seemed to have shaped women’s participation in cancer screening. A few women who were not using the services despite their knowledge and/or doctor’s recommendation clearly mentioned issues other than certain health beliefs (such as, time constraints, gender roles, relative importance of addressing other immediate priorities) for their lack of use of cancer screening. Women who were using cancer screening were quite diverse with respect to their immigration, employment and educational status, income and class position, spoken English skills. But generally speaking, those who were more independent, settled, empowered and aware of these cancers and screening tests, were able to inquire about the tests and ask their physicians to start the screening process even when they did not have any symptoms. Many of the users of these services were also well-connected within the community and/or community organizations and support service agencies. They received important health information and advice from their community support worker and became empowered through the process. The diverse life
contexts (age, literacy, immigration status, access to education, community resources, availability of childcare and extended family support) of the participants shaped their knowledge, perceptions and attitudes about the need of prevention of reproductive cancers. Given the diversity and complexity of South Asian immigrant women’s personal health beliefs and attitudes, socioeconomic circumstances and immigration as well as healthcare experiences, South Asian women should not be stereotyped as having particular monolithic cultural beliefs and understandings about female cancers and cancer screening. Some of the influences that shaped women’s participation in cancer screening were related to the women’s personal attitudinal issues and socioeconomic, immigration and settlement status while others reflected structural issues within the healthcare systems including different physician practices. Among the multiple intersecting factors, two of the systemic and structural issues – physician practices determining the quality of primary care, and women’s gendered and racialized immigration and settlement status shaped by their age or generation, length of stay, education, employment, English language skills and other factors – will be further explored and discussed in the next chapter.
CHAPTER 5: THE IMPACT OF IMMIGRATION AND SETTLEMENT EXPERIENCES ON WOMEN’S HEALTH AND ACCESS TO HEALTH CARE

Introduction

Migration constitutes an experience of significant transition, offering new opportunities as well as many potential hardships. The immigration process – from the decision to migrate, to the journey itself, and throughout the settlement process – is a complicated affair ... the new opportunities that may be associated with migration to Canada occur in tandem with the challenges of migration. As such, it is imperative that both the opportunities and challenges of migration are factored into the equation of immigrant health outcomes (Vissandjée, Thurston, Apale and Nahar 2007, 224).

The main purpose of this chapter is to examine South Asian immigrant women’s access to cancer screening services as part of the broader healthcare system, and to situate and contextualize the issue within the processes of women’s migration, adaptation and settlement in Canada. As indicated in the previous chapter, South Asian immigrant women’s access to breast and cervical cancer screening was shaped not simply by their understandings, attitudes or cultural practices around health, cancer and cancer screening, but also by their diverse migration and settlement statuses as well as by the systemic barriers they encountered in accessing primary health care in Canada. Women’s length of stay in Canada since migration, that is, their settlement status, as well as their literacy and empowerment status were some of the key determinants of their participation in reproductive cancer screening services in Canada. It was mostly elderly women with limited or no education and literacy, and a majority of the new immigrants struggling with settlement challenges and/or lacking familiarity with the Canadian healthcare system, who were not using either or both of the cervical and breast cancer screening services. The various intersecting influences on women’s use or lack of use of these services indicated that women’s gendered and racialized experiences of migration and settlement created the broader social and structural contexts of their everyday lives within which they accessed and/or encountered the systemic barriers to accessing preventative healthcare services such as, cancer screening.
Many of the current research findings presented in the previous chapter were in agreement with those of earlier research in the area. But the intersecting influences of multiple factors on women’s utilization of cancer screening implied that a complex interplay between South Asian women’s personal health beliefs and structural issues within the healthcare system restricted their use of cancer screening. However, the current study also attempted to link South Asian women’s participation in cancer screening with the broader contexts of their migration and settlement experiences in order to explore to what extent and how South Asian immigrant women’s under-utilization of preventive care such as, Pap smear and mammogram, are related to their cultural differences in concepts of health and illnesses like cancer, and as well, to the systemic and structural barriers in the Canadian society. Although a few studies have examined migration as a predictor of low cervical cancer screening among South Asian and other ethnic minority women, migration is most often understood only in terms of length of stay or the number of years women have lived in Canada. But the complex relationships among migration, health and access to health care remain unexplored in such research. Often the low utilization of cervical or breast cancer screening by different groups of immigrant women, including South Asians, are explained in terms of their cultural origin, that is, the ethnicity or nationality of certain immigrant groups is conflated with their culture while ethnicity and culture are viewed as homogenous and static. Examples of such research practices have been cited in the review of existing literature in chapter two. Such culturalist explanations about the possible predictors of low cancer screening by ethnic minority immigrant women fail to take into account the broader contexts of their lives including the challenges faced by recent immigrants. Such essentialist approaches also ignore women’s gendered experiences of migration, discrimination in the job market and the racialization of poverty experienced by most ethnic minority immigrants including South Asians, and often by the second generation visible minority men and women.

In the current study, the issue of South Asian immigrant women’s access to health care and cancer screening services was situated within their migration and settlement experiences which were found to be shaped by intersecting dynamics, such as, gender, category of admission, age, financial in/stability, education level and spoken English skills, access to employment, settlement services and other resources. These intersecting factors not only shaped the diverse experiences of immigration and integration of South Asian women in the current sample, but also facilitated or challenged their access to cancer screening services. The gendered and
racialized processes of immigration and integration were brought to the center of analysis in order to better understand South Asian immigrant women’s access to quality health care including cancer screening, and as well, to counter the culturalist and essentialist understandings of the issue predominant in the relevant literature and scholarship. The current chapter provides a general backdrop of South Asian women’s migration and health experiences against which to understand women’s access to and experiences with the Canadian healthcare system in general and breast and cervical cancer screening services in particular. First, the immigration, settlement and health status of the participants and the relationship among these statuses are examined. This is followed by a discussion of how women’s health and access to health care including cancer screening were shaped by their varied and intersecting socioeconomic and settlement conditions as well as structural factors in the healthcare system.

**Immigration, Gender and Health**

Through an extensive review of existing research on immigrant and refugee women’s access to health care, Mulvihill, Mailloux and Atkin (2001) identified a key gap as well as a prospect for future research in the area as being the context of these women’s lives and how it impacts their access to health services and programs. The authors suggested that improving access to health care for immigrant and refugee women requires an understanding of the circumstances of these women’s lives as shaped by their migration experience, age, country of origin, length of time since immigration, education, location of immediate and extended family, eligibility for settlement and integration programs, language proficiency, level of acculturation, social class and occupation and so on. Following Mulvihill, Mailloux and Atkin’s suggestion, in order to understand the complex contexts and processes that shaped the South Asian immigrant women’s settlement and integration status, and in turn, their access to and utilization of healthcare services in this study, comparisons were made between the experiences of new immigrants and long timers, highly educated and less educated or uninformed women, older and younger generations, and those coming from a rural background and those with the experience of living in a metropolis and transmigrating from a third developed country (the US, UK or Australia). Not all South Asian women were equally challenged by immigration and settlement processes; rather these were shaped by a gamut of intersecting factors – age and generation, education and English language proficiency, immigration/admission category, previous experience of living abroad, economic opportunities and community participation to name a few. All the determinants of
women’s dynamic social locations that shaped their immigration and settlement status also facilitated and/or constrained their access to health care and other related services, cancer screening services being one of them. Accessibility of the healthcare system in general and primary care in particular (determined by women’s lack of English language skills and familiarity about services, gender roles and responsibilities, nature of women’s relationship with family physicians and physician’s gender, race/ethnicity, age) was found to have somewhat shaped women’s access to cancer screening care as well.

**Gendered Experiences of Migration and Settlement**

Immigration is a big decision and a complex process—often an individual choice but mostly a family preference for women. Even some of the women who came as skilled immigrants in this study had decided to migrate to Canada for the sake of their children or family. The participants’ gendered experiences of migration and settlement nevertheless, were mediated and shaped by their diverse demographic characteristics and their interactions with structural issues. Overall, women’s settlement status and level of socioeconomic integration in Canada were impacted by traditional gender norms of parenting and housework which became compounded by the social isolation, financial stress and lack of extended family support experienced by most new immigrants. Women’s experiences in the present study demonstrated that their roles and responsibilities as mothers, wives, caregivers and homemakers were often complicated, amplified and even transformed in the contexts of immigration and settlement in Canada.

Women involved in this study immigrated at different ages for multiple and varied reasons—ensuring better education and a better future for themselves but more so for their younger generations, joining family (husband or adult children or extended family members), and achieving a better quality of life, including an easy access to a high quality healthcare system. Marriage and/or family reunion was the main impetus for immigration for the sponsored immigrants. Accompanying a husband who had decided and applied for immigration was another important reason. Relatively few women came as the principal applicant or as skilled immigrants. Gulmohar, a principal applicant who came to Canada in 2006, had a lot of motivations and attractions, including Canada’s high standard healthcare system—

*...it is a very developed country with a developed healthcare system and other, you know, social*
system. It’s good, and health care, education and everything – the standard of living is good. So I thought that, as Canada is offering immigration, inviting the skilled professionals like us, so as I’m a qualified pharmacist in my country so I thought that as a skilled pharmacist since I qualify and have an opportunity to re-qualify myself in Canada and work as a pharmacist – so all these things … and also the reputation of Canada as a fair society and promoting the multiculturalism – all these things attracted me.

Oftentimes the decision of migration was quite gendered because women mostly joined or followed their husbands to a new country. As one woman said, “It’s just that my husband wished to come here. He wanted to be here. He came here, so we came with him to stay together.” Another woman had a similar experience: “Well, my husband came here before me to make a good life. So I came here automatically [through marriage].” Even a physician with more than one graduate degree from Australia and the US, Camellia articulated the gendered reality of migration decision –

Well, actually I didn’t choose [to be in Canada] because when I got married I knew that my husband lived in Canada and that’s how I’m here. It’s not like I wanted to be in Canada and that’s why I got married with someone in Canada. So, if I didn’t get married with my current husband I could be married with someone else and living with him somewhere else.

Early marriage along with lack of access to education was a gendered phenomenon observed among many participants in the study. Most elderly women experienced marriage at their teen age. For example, a 63 year-old woman had lost her mother at the age of four, and being deprived of education, got married when she was 14 years old. Her story reflects the gendered reality of many South Asian women’s lives –

... we have to do housework and never go school, we have to stay home. Because when my sister got married I have to look after my younger sister and do housework and cooking and everything. And then I get married…When I was 16 I had one daughter. My daughter, she’s the eldest. When I was 17 I had another baby. When I’m 19 I have 3 kids, yah! And we had one small restaurant. And I have to cook every day, make almost 200 roties, 300 roties, everyday!

A couple of young Punjabi women were also married at the age of 16 and 17 and this hindered their education. Both of them also got divorced due to their experience of domestic violence. One of these young Punjabi women articulated her dilemma caused by conflicting messages about gender roles and expectations from her husband and parents-in-law. While the husband wanted to see her as a ‘modern girl’ in Western outfits, the in-laws expected her to be a ‘traditional Indian or Punjabi housewife’:
I was puzzled whether I should change myself according to my husband’s standards or his parents’ ideal. So I didn’t know what to do. If I tried to please him then my in-laws gave me trouble. On the other hand, if I tried to please them he was [so] upset that [he said,] ‘no, I can’t take you out in this kind of traditional outfit!’... But my in-laws wanted me to wear the traditional clothes. So I feel like it was possible to adjust or stay in my marriage but I didn’t get the help from my in-laws. I tried my best.

Migration from an agrarian society to a new Western country at a young age without much education or knowledge of English language and the absence of any close relatives or friends in Canada contributed to this woman’s powerlessness and vulnerability towards abuse in her in-law’s family.

Most of the women in this study were sponsored immigrants. Many women, especially those belonging to older age group coming from rural Punjab of India and Pakistan, did not enjoy access to higher education or sometimes even to basic literacy and opportunities to attain skills and jobs, which is why they came as sponsored immigrants. But some women with high level of education also came with their husbands or were sponsored by a husband or another family member. As Zaman (2006) reported, most immigrant women from Bangladesh, India and Pakistan migrate to Canada as dependents of men because of such reasons as discriminatory practices and sexist societal perception of women, and because, as Asis pointed out, these countries “have very restrictive regulations concerning female emigration, which their governments consider fraught with danger” (2003, 1, cited in Zaman, 32). Moreover, the point based immigration system that is both gendered and classed (Hyndman 1999; Thobani 1999; Zaman, 2006) does not allow women with limited or no formal education and English or French skills to apply for Canadian immigration visa as an independent applicant. The gender and class dynamics of the point system lie in its emphasis on formal educational and vocational training and investment potential, and on occupational experience and skills gained through activities and involvement in the public realm dominated by men (Abu-Laban and Gabriel 2002; Ng 1996). Even when women have education and work experience comparable to men, quite often they are still assigned a status of family or dependent of men due to the patriarchal ideology of male supremacy or implicit gender hierarchies and assumptions about gender roles inherent in the admission categories under Canada’s point based immigration system (Abu-Laban and Gabriel 2002).
The gender biases in the point based immigration system also fail to recognize women’s reproductive and unpaid domestic work that sustain their families and assist in their socioeconomic integration and contribution to the Canadian economy. When I asked the participants about their work (for example, ‘what do you do?’ or ‘what sort of work do you do?’) some women, mostly the elderly, replied, ‘nothing!’ I had to remind them that they actually manage the household – cook, clean, take of their children and grand children and such other important work that hugely contribute to the sustenance and settlement of families in a new country but remain greatly unappreciated and unrecognized, especially because of invisibility of the economic value of such work. I found that cooking, cleaning, feeding children and overall childcare (including taking children to the doctor or to school) were primarily women’s work irrespective of their involvement in paid work. Some women mentioned receiving support from husband and/or other family member(s) including older children but others were not so lucky. As Rose jokingly said, “Men don’t do housework anyway!” Her friend also shared thoughts and perceptions about the gendered division of labour regarding childcare which becomes extra challenging for most new immigrants without the support of extended families –

... men keep us home that you better do work at home. You don’t have to work outside home ... You know, Punjabi people bring their families – parents who can handle the kids. But we don’t have anyone, right? If both of us get out of home then who’s going to take care of the kids? And then men care more about their kids than us, women! ... My husband says, you better stay home and take care of kids. We’ve come here for the sake of kids, for their betterment. We can’t allow something bad to happen to them – they are our most precious assets, right? So for the sake of the kids, we better stay home and work from home ...

Seven of all the women were living in extended families – four of them were from Punjab of India, two from Punjab, Pakistan and one from Bangladesh. Three of the Punjabi women living in extended families mentioned they financially contributed to the family either through seasonal farm work or through pension. All these women provided or received some help with childcare. Older parents mentioned getting support from grown up children (often their sponsors) whether they lived in the same extended family or not, especially in case of any sickness or any need for medical help. On the other hand, those with young children and no close relatives or extended families faced additional difficulties. Gunj, a mother of three children, mentioned that she was managing both paid work and household and childcare responsibilities without much support from the husband or others. She remembered when her children were younger she did not have the time or scope for self-care. Once she went to a physician who noticed her red eyes, which she
was completely unaware of, and the physician said, “Don’t you even look at yourself in the mirror?” As Gunj mentioned, being alone to raise her children born within very shortly spaced pregnancies, she indeed had no time to look in the mirror.

Financial stability can help in coping with the stress of gendered unpaid household work. Dahlia, a well-established upper class immigrant woman in the study, had a paid cleaner, but most new immigrants did not have the financial ability to afford paid help with housework. Financial solvency also is a major determinant of one’s ability to sponsor extended family members to Canada – something most new immigrants, who ironically need the support most, cannot afford. Rose’s comments showed how the precarious financial status of new immigrants can impact women’s workload and leisure time –

*You’ve been given so much relaxation that if you don’t cook food it can be bought from outside. If you have money you can at least give this much to other person that okay, get this done. [For example,] you can do the laundry outside [by cleaners]. But when you’re having kids, you don’t usually have a lot of money, right! Because you’ve newly arrived! When you don’t have money you cannot bring any facility to you. But if you have money you can buy things, you can buy any services from outside. At least that can help!*

Rose’s comments are in line with Willson and Howard’s (2000) observation that immigrant women and women living in poverty are particularly vulnerable to time stress and the health consequences of unpaid work because of their limited or lack of access to time saving devices and resources. Furthermore, immigration to a new country often transforms ‘traditional’ gender roles and increases women’s work load. For example, a couple of housewives in the study mentioned how they were forced to take responsibilities in public spheres as well. For these women the strict gender division between private housework and the public work of taking children to schools and doctors became blurry. As Poppy said, “Everything you have to do by yourself here!” And Zinnia explained: “We go to kids’ school. Kids are completely our [women’s] responsibilities, right! Husbands just work outside and earn money. Dropping off and picking up kids [from school], taking them to doctors when they are sick – everything is my responsibility.” Zinnia also shared a story about how difficult it was for her to handle the new challenge of banking in public, something she had never had to do back home. As her friend Rose laughingly commented: “Some women don’t even know where to sign on a check!”
While South Asian women participating in this study reflected on gender issues and their intersections with immigration and socioeconomic status, their gendered roles and practices are often viewed as cultural rather than structural issues. For example, Choudhury (1998) commented that responsibility for the well-being of others, patriarchy, and cultural norms hinder many South Asian immigrant women from focusing on themselves. Another study with South Asian immigrant women reported that their cultural tendencies of strong familial orientation result in low priority for self-care in the presence of competing demands (Bottorff et al. 1998). These ‘cultural’ tendencies have also been reported to influence low cancer screening rates among these women (Choudhry, Srivastava and Fitch 1998; Gupta, Kumar and Stewart 2002). However, what these studies lacked is a serious examination of how the migration factor interacts with these gendered ‘cultural’ practices. South Asian women, unfortunately, are often disproportionately and stereotypically represented in the women’s health literature as the ‘victims’ of gendered roles in families and communities. What is missed from such a simplistic gender analysis is the interaction of gender with immigration experience – migration to a new Western country most often magnifies or even deteriorates women’s gendered isolation and exploitation. Women’s experiences in this study uncovered how gender ideologies interact with the material conditions of immigrant women’s lives which are shaped by discrimination, racialization and other challenges in the Canadian labour market and society.

**Challenges of Immigration and Settlement**

Immigration brings up new expectations, opportunities and roles for women, but also poses many challenges. Participants in the study encountered such challenges as language barriers, systemic racism and discrimination, and financial insecurity and stress caused by under/employment, isolation, loss of family ties, support and social status, especially during the first few years of immigration – phenomena commonly found in the literature on racialized immigrant women (Guruge and Khanlou 2004; Vissandjée, Thurston, Apale and Nahar 2007). However, the challenges faced by the women varied according to their immigration and settlement statuses – new immigrants had challenges different from those of long time residents. And the challenges as well as women’s different abilities to overcome those also varied according to the categories of admission/immigration, their ages, levels of education and English language proficiency, previous experiences of living in rural or metropolitan areas in their home
or other developed countries. Length of stay was noted to be an important determinant of successful settlement and economic integration. Most women seemed to have somewhat settled down after about ten years, but the time factor was also related to other intersecting dynamics, such as age, generation, educational qualifications, category of immigration, childcare or family responsibilities, availability of support system and connections. A comparative demographic and sponsorship status of new immigrants and long time residents is shown in Table 5.1. on the next page.

Finding accommodation, employment and a family physician are among the first few concerns for most new immigrants. For many South Asian women, who had come as sponsored immigrants under the family class, most of these concerns were taken care of by a husband or an adult son/daughter or other family member(s). Most of the long-timers in the study (who had lived here for about 10 years or longer) were sponsored immigrants and usually did not provide details of their immigration experiences or challenges of settlement in a new country. Many of them had minimum or no literacy and/or English speaking skills. But they had already managed to learn how to negotiate with the challenges of settlement and adjusted to the new systems with the support of relatives, family and friends and/or community organizations. These women were very satisfied with the immigration process and outcome, and did not encounter many difficulties. For example, Jasmine, a 70-year-old Punjabi woman sponsored by her son and a retired seasonal farm worker with no formal schooling, replied with much confidence when asked if she ever had any problems due to her lack of English language skills: “What do I need English for? My children are from India – they speak Punjabi!” She was also living in a neighbourhood with a concentration of South Asian residents and grocery stores. Her Punjabi speaking neighbours and friends who were sitting there during the interview also nodded in agreement with her. Thus many of the sponsored immigrants did not feel particularly challenged by their lack of education or English skill because of the family and community support they had received. However, some women did mention their lack of English skills as a major hurdle, encountered particularly in accessing health services, especially during the first few years after their immigration (this will be discussed in a later section).
Table 5.1: Comparative Demographic and Sponsorship Status of New Immigrants and Long-Time Residents (N = 30)*

New immigrants (length of stay: 1 – 5 years); Age range: 34 – 61; N = 9

<table>
<thead>
<tr>
<th>Immigration category</th>
<th>Occupational status in Canada</th>
<th>Highest level of education</th>
<th>Occupation at home country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal applicant (5)</td>
<td>Looking for a job (3)</td>
<td>Graduate (5)</td>
<td>Professional (4)</td>
</tr>
<tr>
<td>Spouse of a principal applicant (2)</td>
<td>Housewife (2)</td>
<td>Diploma (2)</td>
<td>Semi-professional (2)</td>
</tr>
<tr>
<td>Sponsored by husband (1)</td>
<td>Academic (1)</td>
<td>High school (2)</td>
<td>Housewife (2)</td>
</tr>
<tr>
<td>Sponsored by daughter (1)</td>
<td>Semi-professional (1)</td>
<td></td>
<td>Student (1)</td>
</tr>
<tr>
<td></td>
<td>Part time service job (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retired (1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Long-time residents (length of stay: 7 – 27 years); Age range: 30 – 76; N = 21

<table>
<thead>
<tr>
<th>Immigration category</th>
<th>Occupational status in Canada</th>
<th>Highest level of education</th>
<th>Occupation at home country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsored by a family member (14)</td>
<td>On disability benefit (6)</td>
<td>No schooling (6)</td>
<td>Unknown (6)</td>
</tr>
<tr>
<td>Spouse of a principal applicant (4)</td>
<td>Housewife (5)</td>
<td>Graduate (6)</td>
<td>Housewife (5)</td>
</tr>
<tr>
<td>Sponsored by husband (3)</td>
<td>Retired farm worker (3)</td>
<td>Secondary (5)</td>
<td>Semi-professional (4)</td>
</tr>
<tr>
<td></td>
<td>Fulltime semi-professional (2)</td>
<td>Diploma (1)</td>
<td>Student (4)</td>
</tr>
<tr>
<td></td>
<td>Self-employed (2)</td>
<td>Primary (3)</td>
<td>Family business (1)</td>
</tr>
<tr>
<td></td>
<td>Seasonal farm worker (1)</td>
<td></td>
<td>Seasonal farm worker (1)</td>
</tr>
<tr>
<td></td>
<td>Part time service job (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retired (1)</td>
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</tbody>
</table>

*One woman, a member of a support group interviewed together with the other group members, was born in Canada; hence not included here
Many recent immigrant women in the study experienced the emotional stress of leaving parents and extended families behind. Zinnia came from a close-knit middle class extended family a few years back. She said, “I miss my home a lot. I would have gone back if possible!” Her friend Poppy felt slightly differently because she had somewhat settled here: “When I first came here I used to cry a lot! I didn’t like it first time. But second time I’ve got used to it. Now I’m starting to like it…” Rose had been living in Canada for over-10 years and she described how she went through the initial social isolation:

When I came here I didn’t know anybody here. I was all alone, so, like, lonely! My husband left for work early in the morning. He came home late at night ... and even my husband didn’t know [people] because he was living in Toronto [before]. When I came with him he moved to Vancouver. So even this city was new for him and for me ... So few times I went to mosque to see if I knew any people. So they were mostly Arabic people so I didn’t go even there. I didn’t know about the Fraser street, Main street – I didn’t even know there was such an area. I was living in an area [where] just totally, like, white people live. Slowly we got to know things and people and it was so much easier. But like, first, 3 or 4 years, we lived in an area – so unfamiliar ... I didn’t even see any women in salwar-kamiz [traditional South Asian outfit] ever ... all white [people] ... I used to cry a lot ...

Immigration to a new country can actually constitute a stressful experience and a difficult process of adjustment, especially during the first few years of settlement when many experience a declining social status. Deepa, a primary school teacher on early retirement, stated her downward social position: “I was in service for 35 years as a teacher and centre head teacher. Here I can’t do anything! I feel like my status has gone down!” She also shared her depressing observation about the low status of skilled South Asian immigrants in Canada –

Our kids with good education from India come here and do odd jobs here. Someone is a doctor or nurse from India, or is qualified in some other professions – both boys and girls – they work in restaurants, Subway! In India they didn’t do such jobs! In India you have a maid servant for doing dishes, another one to do your laundry. But here you have to do all by yourself. If you don’t then you can’t pass the days or live a life here.

A few women, however, said that they were mentally prepared for such challenges and difficulties for immigrants in Canada. Dahlia, well educated and fluent in English, was one of the women who were mentally ready to start everything all over again in Canada. The descent from their upper middle class status back home, the lack of validation of her and her husband’s educational qualifications and professional experience from home were accepted rather easily. Within few years they were able to retrain themselves, gain Canadian certifications, establish their own business and become successful. According to her conviction, “If you work hard, keep
faith in God and pray regularly, everything will be all right – kids will be on track; life will get better and prosperous.” Although Dahlia emphasized hard work as the determinant of her success, she could have acknowledged the contribution and help of her well-established elder brother, who, as she mentioned at another point, had provided huge initial support. The geographic location of the house she and her husband owned made their life much easier by giving easy access to husband’s office, children’s schools, doctor’s clinic and ethnic grocery stores, and also helped her to stay well-connected within the community [Field note].

Compared to the long time residents, the majority of the recent immigrants in this study were educated and professional women and they were also principal applicants. Four out of six newly immigrated professional and semi-professional women expressed concerns about the problem of unemployment and underemployment. They were also worried about their mental state – stress and depression resulting from un/der/employment and financial constraints. Champa, an experienced lawyer from a South Asian country, shared her initial shock over lack of jobs for skilled immigrants: “It is very hard to adjust yourself in Canadian system unless you have some Canadian experience or Canadian certification from Canadian institutions … It’s, I mean, impossible to get a good job – yah!” A couple of long time residents with graduate level education also recalled the dim job prospects in the mid 1990s although both of them came to Canada mentally prepared to start with low status jobs. Henna came in 1995 and when asked about the most difficult challenge she faced after coming, she replied, “getting a job – because when we came here, there was a deep [economic] depression. It was very difficult to even get an odd [menial] job ... you wouldn’t get a job even in McDonald’s or any food store.” In fact, the employment situation of recent immigrants has not changed much. Recent statistics reveals that in all provinces of Canada the labour force participation rates in 2009 were lowest for very recent immigrants (lowest in Quebec – 67%, followed by BC – 71%), and the rates increased as immigrants became more established. Unemployment rates for very recent immigrants were much higher than for Canadian-born in every province except for the Atlantic provinces. Furthermore, Canadian-born workers had significantly higher wages (26% to 54% higher) than very recent immigrants in all provinces, except the Atlantic provinces (6% higher) (WelcomeBC 2009).
The past experience of living in a Western or relatively/developed country (USA, UK, Australia, Russia, Japan, Fiji and Tonga) facilitated the transmigrant women’s adaptation and settlement process in Canada, especially compared to the women who had migrated from rural areas. However, the education and training received by some of the women from USA, Australia and Russia were not necessarily accredited in Canada. Six of the participants had lived in a foreign country before immigrating to Canada, and all these women were highly educated. Four of them had received a graduate level education from a Western country, while three of them came to Canada as principal applicants. But only one of these highly skilled women had a professional job and three women were unemployed at the time of the interview. Ironically the education and job experience that had helped women getting immigration visas no longer seemed to be useful in getting jobs because they were not validated by the Canadian education system and labour market. A couple of recent skilled immigrants mentioned how they had already accepted the reality of underemployment in Canada and were ready to start from the most basic or lowest level positions, but within their own professional field: “Say, if I, I’m a teacher, I don’t mind working as a teacher aide ... because I’ve accepted it and come, right! I didn’t come as if I’m going to have the director position here ... [but] you cannot tell me, ‘take the broomstick,’ you know!” Champa felt that it is disgraceful for a skilled woman to start working completely outside her professional field but she realized that it is the financial struggle or poverty that force new immigrants to do such jobs –

*You have a good experience in a very prestigious field and you want to go to a job, and you are working in Wal-Mart or Sears, or Canadian Tires! So I feel it’s bad for myself – I didn’t get any job in these departments but if, suppose, now I’m financially too much constrained – we are really striving [to survive]. Yah, really very difficult! So the thing is that if you want to take a start – so from where you should take a start? Like, Canadian Tires, like Sears, like Wal-Mart?! So they do say that you’re skilled worker but when we come over here then we see that there is no job and you have to go to Sears and Wal-Mart!*

Many new immigrants had to compromise and take a survival job, and accept part time jobs with inflexible hours. Some women had to negotiate paid job with family and childcare responsibilities. As a new immigrant, Henna faced special challenges to arrange childcare for her young children, especially on weekends when both her husband and she had to work. Ivy mentioned the lack of flexibility and choice of working hours for new immigrants: “Because we’re still getting settled, right, so I have to say yes to everything that they offer to me – whatever hours are available no matter what time of day!”
However, some women also shared their success stories; some became successful more quickly and easily than others. Those who lacked education and English skills were forced to work multiple menial jobs. For example, Juhi, a widow with little education and family support, had to work extremely hard to survive and settle in the late 1980’s—

_I start[ed] working in factory, egg factory. I make 5 dollars an hour. I start 6 o’clock morning. And I finish 4:30 – Monday to Saturday. Then [after] I finish [at] 4:30, I go downtown Camby Street and do dishwashing. Then when I come home it’s sometimes 1 o’clock, 1:30 am, yah! Then I wake up [early morning again]. Everyday – almost 4/5 years I got to do this._

Her hard work paid off although she also acknowledged support from the Canadian government (for example, access to subsidized housing). When asked about her current socioeconomic status, she confidently replied, “I think I can say upper middle class. Yes, we have nice house, nice car, nice clothes and jewelries – everything one needs for a good life and we have it all!” Bela came with a graduate level education and experience of teaching in a school. After her initial struggle for a number of years she felt that she became quite settled in 14 years, financially as well as mentally – “I took whatever was available first, right that moment and from there I kept upgrading. I went to school to study and upgrade and now I’ve somewhat settled down. […] Now I’m working in … as an assistant manager … So I’m enjoying it.” On the other hand, migrating with a professional job in hand gave financial, social and mental stability, and made settlement easier for Daisy, a young woman who was born in India, raised in Kenya but educated in and migrated from England. Fluency in English, experience of living in a Western country, and an outgoing, independent and assertive personality seemed to have helped Daisy’s easy settlement—

_Everybody was saying, oh it’d be so difficult! [But] I find it very easy! I’m always going out, always going out of my comfort zone. So then if you go out a lot you don’t have any problem. I don’t have problem making friends. You stay at home and you’re timid and shy then you have a problem … Yah, it was a lot easier – so that was a quicker process to do it [immigration visa] through job … So get a job first and then settle yourself – you get a life within the job and then – I think it’s a lot easier than coming over here with nothing and then start over._

The complex intersections of several factors determined the time and ease with which the immigrant women in the study had achieved or were striving to achieve successful integration in Canada. But immigrants generally take much longer to catch up with the success rate of non-immigrants. Immigrant women usually have to work extra hard compared to both immigrant men and non-immigrant women. Zaman et al. (2007) reported that recent immigrants struggle long
and hard to reach the economic standards enjoyed by most Canadians, and that immigrants suffer a long transition penalty. These authors also referred to a Statistics Canada (2007) report that in 2006, very recent immigrants (those who have been in Canada five years or less) had the most difficulty integrating into the labour market, even though they were more likely than the Canadian-born population to have a university education. The narratives of South Asian women participating in this project testified to these facts. Nevertheless, it became evident from the different stories women shared that not all immigrants were equally challenged. Different demographic, socioeconomic and structural factors affected South Asian women differently in terms of their immigration and settlement status.

The Impact of Immigration and Settlement Status on Women’s Health

Overall, the experiences of the research participants indicated that “[t]he relationship between migration and one’s health outcomes varies with the impetus, experience, and outcomes of migration, as well as with the everyday processes of integration” (Vissandjée, Thurston, Apale and Nahar 2007, 224). South Asian women’s experiences in the current study also supported earlier research findings that new immigrant women are particularly likely to experience stress in relation to economic circumstances, the negative attitudes of some Canadians towards them, and personal isolation – all of which cause physical and mental distress (Choudhry 1998; Status of Women Canada 1996). Most new immigrant women who faced financial stress due to un/der/employment and/or lack of family and community supports also experienced tremendous mental stress and seemed to be in vulnerable positions. Such positionalities not only tended to pose unique health challenges for these women but also made it difficult for them to use preventive care, such as, reproductive cancer screening.

Most women in this study, especially the young or middle aged and recent immigrants, mentioned being ‘fit’ or in good health at the time of immigration. Nineteen of the 31 women reported having some sort of chronic conditions, whereas 12 women asserted having no health problems. Hypertension was the most prevalent chronic health problem followed by diabetes. Only two of the 19 women with chronic conditions were recent immigrants; others had lived in Canada from seven to 27 years. This is congruent with the findings of Ali (2002); Gee, Kobayashi and Prus (2003) and Perez (2002) who noticed fewer chronic illnesses among new
immigrants. The table below shows the prevalence of chronic health conditions among the women as related to their length of stay in Canada.

Table 5.2: Prevalence of Chronic Health Conditions among South Asian Immigrant Women

<table>
<thead>
<tr>
<th>Length of stay in Canada</th>
<th>Average age &amp; range</th>
<th>No. of women with chronic health condition(s) (N = 19)</th>
<th>Total no. of women (N =30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 5 years</td>
<td>45 (35 – 55)</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>7 – 10 years</td>
<td>53 (37 – 56)</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>12 – 20 years</td>
<td>49 (31 – 70)</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>More than 20 years</td>
<td>60 (46 – 76)</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

excludes one participant who was born in Canada

The table shows that all of the women (five out of five) who had lived in Canada for more than 20 years had one or more chronic health conditions whereas only two women among all the recent immigrants (N=9) had a chronic disease. The women with a greater number of years in Canada also were older than the recent immigrant women with chronic health conditions. Overall, the recent immigrant women had fewer chronic physical health conditions but more mental stress, anxiety and depression. Although increased length of stay was one of the important determinants of women’s successful settlement and integration in Canada and also a positive influence on women’s use of cancer screening services, it tended to have a negative impact on women’s chronic health conditions. It should be mentioned that most of the women with chronic health problems were using at least one or both of the cancer screening services; but five of these women never used a mammogram, and three women never used a Pap smear while two women were unsure of their use of Pap smears. Although all of these non-users of cancer screening visited their family physicians on a regular basis for treating their chronic conditions, only one woman mentioned receiving a physician recommendation for a Pap smear. While having treatments for chronic health conditions were often related to having cancer screening done for some women, a number of women were busy or only able to manage health problems that needed immediate attention and rather postponed cancer prevention over other priorities due to time constraints and other barriers as mentioned in the earlier chapter.
Several studies have observed and reported that even after controlling for age, socioeconomic status, and time since immigration, immigrants in general have a lower prevalence of chronic illness, depression and alcohol dependency compared to the Canadian-born population (Ali 2002; Gee, Kobayashi and Prus 2003, 2011; Perez 2002). New immigrants in particular, have fewer chronic illnesses and less disability than Canadian-born and long-term immigrants do. But compared to the general population, some specific chronic health conditions, such as heart disease, diabetes, cancer and hypertension have been found to be more prevalent among immigrants particularly in relation to their increased length of stay in Canada, suggesting a deterioration of health over time (Perez 2002). One prominent explanation of this fact known as the ‘healthy immigrant effect,’ or the gradual loss of health and well-being among immigrant population since the time of immigration, is focused on individual lifestyle and health practices. It assumes that as immigrants become more assimilated into Canadian society they may adopt certain lifestyle practices and health behaviours such as smoking, excessive drinking and food habits that are common in the host country, thereby resulting in similar health status (Ali 2002; Perez 2002). However, Gee, Kobayashi and Prus (2003) emphasized that health research, healthcare policies and programs must take into account the health impacts of the intersections between country of birth, length of time since migration, immigrant status, age, ethnicity and gender of immigrant men and women rather than simply considering their lifestyle and health practices. A number of these intersecting factors also are likely to determine the rate at which lifestyle behaviours of immigrants converge to the Canadian norm. Yet, some researchers have also rightly recognized that factors such as poverty, unemployment, discrimination, difficulties accessing services and language barriers may potentially contribute to and accelerate the deterioration of immigrant health status. The ‘healthy immigrant effect,’ Vissandjée, Thurston, Apale and Nahar (2007) argued, could be the result of the many challenges of immigration and settlement in a new country. Therefore, they insisted, women’s migration experiences need to be acknowledged and understood as an important determinant of their health.

The challenges immigrant women face in the new host country considerably influence their health and access to health care (Guruge and Khanlou 2004; Vissandjée, Thurston, Apale and Nahar 2007). Financial insecurity and stress caused by un/der/employment, isolation, loss of social status, family ties and support were some of the common challenges experienced by the
women in the study. These challenges caused physical and mental stress, which in turn impacted many women’s health. In the current study almost all the recent skilled immigrants voiced their frustration and mental stress due to non-validation of their professional degrees and lack of employment in their desired field of expertise. Lack of employment and financial problems can create barriers to successful integration and settlement for new immigrants and impact their health. Camellia described the impact of such systemic discriminations on her mental state –

*I’m frustrated for sure! I can’t get a job despite all these foreign degrees [from Australia and USA] in my pocket! All these degrees are in vain! These degrees will give you jobs in other countries but not here! This is very hard to accept ... It’s a lot of stress! No matter how hard I think I wouldn’t stress out I can’t help it!*

A lack of a job or any earnings created not only financial stress but also a feeling of helplessness for Camellia due to economic dependence on her husband: “If I had a job at least I wouldn’t have to ask for money from my husband. Like right now, I have to ask for even pocket money from him. So I definitely feel helpless in that sense, right!”

Such financial constraints and the resulting mental stress among most recently arrived immigrants are quite commonly reported facts. Lee (2000) found extreme poverty rates among recent immigrants (52.1%) next to the rate among Aboriginal people (55.6 %) in most communities in Canada. A study report authored by Dominique Fleury and released by Human Resources and Social Development Canada (July 2007) on poverty and employment situation among recent immigrants to Canada concludes that recent immigrants to Canada face more employment barriers than other working-age Canadians do and they are a lot more likely to experience poverty. The study even found that the difficulties encountered by new immigrants have worsened in recent years (cited in Zaman et al. 2007). Sixteen participants in total reported their yearly income to be less than $15,000 in the present study; five of them were new immigrants while seven women were on disability benefit (all of them also were survivors of family violence), three were elderly women without any literacy involved in or retired from seasonal farm work, and one was a young single mother. A number of these women talked about the health impacts of the financial as well as other challenges of immigration on their health. In general, women’s narrative suggested that the process of immigration can cause physical, mental and financial stress and can affect their health. Gulmohar, a recent skilled immigrant who was
working on getting Canadian accreditation, mentioned how she was meagerly sustaining life since immigration through maintaining “a rock bottom lifestyle” and compromising her previous quality of life until she could prove her qualifications to practice as a healthcare professional in Canada –

*It is far less than what I used to live like back home. So in a way you could say that my living condition or quality of life has much deteriorated ... Because it’s quite expensive here, even the basic living. So I’m living the very basic way... Probably if I had a choice I’d have a better living condition. I’m accommodating with the current situation and focusing to qualify myself. I know that once I qualify, things will be changed. I wish I could afford a better lifestyle. But it is okay for the time being.*

As a new immigrant Gulmohar also was concerned about the high cost of medicine in Canada and she said, “Even I have some medicine from home so I don’t have to buy here ... so health care cost is minimized.” She also articulated how the stressful process of settlement became more intense due to the loss of support and reassurance from family and friends –

*Mentally, there’s lots of stress, like, going through this settlement process, especially the professional upgrading ... Also like, I miss extended family, especially my mother. And also, like, the social life – friends and family over there. Yah – that is also something I always miss! It would be a source of comfort and pleasure – I miss that!*

Leaving a support system behind can cause much stress and negative impacts on the health of many immigrant women. Champa, a highly skilled professional new immigrant, whom I found to be extremely hardworking, patient and optimistic, articulated how all the stress caused by having to raise two young children including an infant in a nuclear family, going to school, unemployment and financial constraints impacted her health –

...I can see that okay, my health has been affected because of my financial constraints and this kind of stuff. But because I’m hopeful that okay, I don’t have enough money to take good food but I think okay, for my baby I always try to buy good food, balanced food as they are in growing age. But for myself and my husband it is a problem. But we are coping up with all those problems and hoping that okay, maybe one day we will have these problems out of our life... but during this immigration process, after coming to Canada my health has been affected too. On many occasion[s] I felt that yah, it is not as good as before and it is because of stress.

Another new immigrant with financial constraints, Zinnia described how she endured extreme physical pain due to the hard work to make extra money while staying home and managing family and taking care of young children. She talked about her back pain – how it got worse because of her effort to make a meager earning through seamstress work –
I had the problem before coming [to Canada]. But it wasn’t so bad or serious before. It was like, occasional minor back pain. But after coming here, maybe because I started sewing and tailoring, so maybe it got worse due to that sewing for one year. It became so bad that I was completely bedridden.

Bela, a long time resident, also mentioned how the physical stress of her menial job impacted her overall health. She also believed many South Asian women suffer from similar problem –

... I noticed that after working for a long time standing on my feet for 8 hours at a stretch I started having joint pains. And since then I started having swelling legs and feet and many more physical or medical problems related to this. I saw doctors and still taking medicine but I know I’m not alone – a lot of South Asian immigrant women I know also have similar complaints because we’re required to work standing on our feet for such long hours for so many years. For women like us, we’re not used to with this so we have problems due to that. And it was really bad for me and that’s why I had to change my job.

On the other hand, Daisy, who applied for immigration visa after securing a professional job in Canada, did not find the immigration process to be stressful at all, at least financially. She was very healthy and happy except she faced stress due to discrimination at her workplace –

The ethnic minorities – they are talked down upon a lot... always very disrespectfully … if you do anything good, nothing is praised whereas if you do something [wrong] – even for the slightest thing – so much pressure and that sort of thing! That I think is discrimination where you’re not treated with respect.

She had to use regular message therapy in order to relieve the stress from work: “Oh I get massage every 2 weeks because the thing is, the stress goes in my back where it’s tightened or whatever!” Fortunately, the health insurance from her well-paid professional job made the massage therapy highly affordable and accessible for her: “I loved it there. They [health insurance from work] pay 80% of it so in the end I pay what, like, 8 dollars! So it’s nothing!”

Women who had children and were engaged with housework and childcare also experienced stress and exhaustion due to difficulties in raising children alone and lack of support in the family. Juhi, a healthy, physically strong and hardworking mother, worked two menial jobs in order to have a better life in Canada. But as a lone mother with two jobs she had not been able to spend sufficient time with her youngest son whom she often had to leave home alone. Ultimately the son became irregular and a delinquent in school, and caused anxiety and health problems for Juhi: “I get very high blood pressure because of thinking [and worrying] all the time [about the son], very high blood pressure!” Kamini, an immigrant single mother with two
young children, had survived and overcome the symptoms of depression and multiple stresses
due to financial hardship and a divorce resulting from family violence. She described how she
fought against all these odds in order to stay in good health for the sake of her children –

*I was quite depressed and I used to get mad at my son for small things ... I try hard not to show
my anxiety or problems to the kids and try to appear happy in front of them so they can be
happy. But still, there were financial problems and other problems and if my ex-husband had any
problems he’d treat the kids bad – all these affects your health. You need to make yourself really
strong ... otherwise if I’m in tension I tend to gain weight. Some people lose weight but I tend to
gain more. I often used to get very irritated. But I controlled myself and now I’m better.*

Some other women also thought they should stay healthy because sickness can make
taking care of family and children even harder and more stressful. Three friends expressed their
thoughts and feelings in this regard –

*Rose: yah, I try to keep healthy because if I’m sick who’s going to take care of my four kids!
Zinnia: yes, I always think this way –
Poppy: I pray a lot to God that no mother may ever get sick! May everybody stay healthy!*

Immigrant women from India in Choudhry’s study (1998) also provided altruistic rather than
personal reasons to stay healthy – for the sake of their children and family. But some women in
the study mentioned some health advantages of migration to a developed country with an
improved healthcare system. Poppy felt that she became more aware about health and taking care
of herself after coming to Canada. She thought, “Women here take very good care of themselves.
When I came here I noticed that. But in Pakistan women are not that conscious.” She also
thought that other Pakistani women also take better care of themselves after coming here –

*Pakistani women, when they come here then they take very good care of themselves. Like, having
check-ups every year ... so that we know beforehand that something is changed in our body or
not. So we can go to the doctor right away to check up and get treatment and get rid of the
tension and everything.*

Rose, a friend of Poppy, also supported the idea that having immigrated to Canada, Pakistani
women develop better health-consciousness and take advantage of the free access to healthcare
services in Canada. Many other women in the study also were health conscious and participated
in different health promoting activities at different levels. Although the gendered roles of
parenting and housework challenged some women’s time and effort for self-care, Bela
mentioned how she was ensuring self-care despite all the stress of managing a full time job along
with her household duties and responsibilities for a child with special needs: “I also started
taking small, simple courses like, childcare and crafts-making – because that was my hobby and I needed that hobby just to hold myself together – without that I’d have lost my sanity! That was my way out [from stress]!”

However, the gendered roles of homemaking and care-giving along with the challenges of immigration and settlement do impart particular impacts on women’s health and their access to health care. Consistent with the findings of Maclean, Glynn and Ansara (2003), some immigrant women in the present study tried to balance the ‘double shift’ of domestic work and paid work, and became vulnerable to time stress and its harmful effects on mental and physical health. And as discussed in the earlier chapter, these issues also influenced some of the participants’ lack of use of cancer screening services. Choudhry (1998) pointed out that women’s gendered roles may isolate them and hinder their participation in community organizations and activities and such isolation also limits them from accessing health promotion and prevention programs. Moreover, migration to a new country often disrupts people’s social status and lifestyles, and this creates health consequences and barriers to health promoting activities. For example, due to the stress and time constraints resulting from immigration to Canada, good health, recreation and exercise – all became a thing of past for Champa: “My health was fine … I was a regular exercise lady! Every day I used to exercise in the morning. I was regular to go to [gym] for my sports. I like playing squash, and every evening I played for one hour. Yah, I loved to play squash.” Choudhry’s study (1998) also found that immigrant women from India had knowledge about healthy lifestyle and health promoting behaviours but as a result of migration, many were unable to continue some of those practices.

Bela, a participant in this study, believed that it is absolutely important for women to take care of their reproductive health. She also thought South Asian immigrant women may have increased vulnerability towards getting female cancers due to migration to a modern Western country, and therefore, it is particularly important for South Asian immigrant women to get cancer screening in context of the transformation of their “lifestyle and way of work or work habits” in Canada. As she explained –

[W]omen in our [home] country, when they work, like, sit to do something or cook, they often stretch or squat and that’s sort of an exercise as you bend your body and knees. Women in our country inadvertently do some kind of physical exercise [just through their daily housework]. So, our women, even though sometimes they may have other problems but they usually don’t have
many other [gynaecological or cancer] problems. But here, when a woman works standing on her feet for 8 hours then, she is not bending or sitting down, getting up and down a number of times, she’s missing the regular kind of physical exercise. Then it causes some special physical or health problems. That’s why these kinds of tests are very important in the Canadian context.

Bela’s point resonates with that of Abdirizak Karod, director of the Somali Centre for Family Services in Ottawa. According to a CBC news report (February 17, 2010), Karod said, “In Somalia, exercise is a part of everyday life … That prevents a lot of the diseases that we are facing here in Canada or in Europe.” Bela thought that the “modern-day gynaecological problems,” including reproductive cancers, are by-products of the Western lifestyle – increased dependence on modern appliances and amenities that demand less physical labour. Moreover, the kind of physical labour demanded from the service based industries in Canada, such as food and customer service – the job ghettos for most South Asian immigrant women due to language barriers and/or lack of accreditation of their educational qualifications, is also detrimental to these women’s health. Many South Asian women, especially those coming from rural and less-industrialized areas, freshly experience these physical challenges as well as technological facilities that do not necessarily promote health. Therefore, in Bela’s view, just as these women need to get used to changed lifestyle and work habits, they also need to have cancer screening done because of their exposure to increased risks of getting such cancers through migration to a modern Western country.

Although it is not known if the incidence of cervical or breast cancer is any higher for South Asian women living in Canada compared with South Asian women in their home countries, Daisy’s experience shows how migration to a new country may interrupt the regular health behaviour practiced back home and demand special attention and effort to put everything back in order. Daisy, a young healthy single recent immigrant professional, never used a Pap-test in Canada. Before migrating to Canada, Daisy had used Pap smears in England regularly through a process of getting a timely reminder letter from her family physician. But after coming to Canada she forgot to take any effort or initiative in this regard because her physician back in England took responsibilities for regularly conducting the cervical cancer screening. She did not have a family physician yet in Canada because her needs were well-met through visiting a walk-in clinic in her vicinity. Due to her familiarity and comfort with the health system back in England she was getting all the medicine she needed (including birth control pills) through
frequent visits to England because it was completely free of cost and easier to get. As she mentioned –

*I still haven’t used any Canadian medicine yet. And maybe I won’t ever need to! ... There will be medicine that’s different here. Like, still my Paracetamol, I get them from England ... I’ve just been nervous of using Canadian medicine because it’s not the same. I just get a whole load, like, once in a year when I go to England. You just make the appointment at family planning clinic and they just give everything there. I don’t have to pay.*

Daisy’s stable economic condition due to a full time professional job in Canada made this frequent transnational movement possible. During the interview she realized that she did not do a Pap smear in Canada because she did not get a reminder, and that was because she did not have a family doctor! At this point she realized the importance of having a family physician in her new country of residence –

*Okay so maybe I’ll have to register here with a family doctor I guess. Yah, that’s why I haven’t got a letter yet! That’s probably why I didn’t think about it – oh yah, yah! [laughing] I think I have to register. Because I should be getting many [letters] – yah, yah, I forgot about that!*

Thus moving to Canada disrupted Daisy’s use of cancer screening services that she regularly used prior to migration. Even though she had no language barriers or financial struggle or family to support, she was in the midst of a new environment and unfamiliar systems and forgot about doing a Pap smear due to the challenges of movement to a new country through immigration. It is imaginable that immigrant women, who have to deal with multiple barriers such as family responsibilities or financial struggles or language problems, would be more likely to become distracted from practicing preventative health care. Remmenick’s (1999) study of breast screening practices among Russian immigrant women in Israel found that two thirds of surveyed women underwent breast-screening practices prior to migration but only one third continued with the practice following migration to Israel (cited in McDonald and Kennedy 2007, 325).

Similarly, Champa had used Pap smears twice in the US before moving to Canada as a skilled immigrant, and having had a hysterectomy, Ivy had used mammogram twice in India before immigrating to Canada. Despite having the knowledge and previous experience of using one test or the other, none of these new immigrants had used any of the cancer screening services in Canada. But it was not due to their shared ethnicity or culture, rather the gendered experiences of immigration and the common challenges of settlement and integration in a new country put these women into the vulnerable situations and made it difficult for them to maneuver through the
novel healthcare system in Canada and use preventive care, such as, reproductive cancer screening.

**South Asian Immigrant Women’s Access to Health Care and Cancer Screening Services**

Accessibility of health care is an important determinant of women’s health and one of the fundamental principles of the Canada Health Act. Access to health care is a complex concept and it has been understood and defined in the health services literature differently in different times and contexts. It usually encompasses geographical, organizational and financial aspects as well as effectiveness and outcomes of health services. Thus it considers all the factors – distance from services, transportation facility, time, cost and individual’s financial ability or access to other resources and capacity to deal with the healthcare organization, and also the effectiveness of the medical care received or provided – as determining the accessibility of health services.

Reviewing many aspects and definitions of access and their relationship to levels of health service utilization, Travassos (2006) suggested three different but interrelated types of access: potential access, realized access and effective access. Potential access refers to the ease with which people can obtain medical care, while realized access indicates the actual utilization of health services in an adequate time to obtain the best possible result. And effective access represents the quality of care – patients’ satisfaction with providers’ practice, as well as providers’ attitudes about patients’ personal characteristics.

Most research and data on South Asian women’s cancer screening tend to focus on potential and/or realized access to breast and/or cervical cancer screening services. Health research that mainly focuses on potential barriers to cancer preventive care for South Asian immigrant women – cultural beliefs and understandings and lack of English language proficiency being some of the most frequently identified issues – tend to provide only a partial picture of the women’s access to these health services. They seem to ignore the experiences of South Asian women who actually use the care and are affected by the quality and effectiveness of the care they receive. Very few studies (for example, Bottorff et al. 2001, and Grewal, Bottorff and Balneaves 2004) have examined South Asian women’s perspectives on the quality of cancer preventive care. Access barriers to cancer screening that are engrained in the Canadian healthcare system and especially, those rooted within women’s immigration, settlement and
integration processes are still relatively ignored in the literature. In the present study, I have examined South Asian women’s access to these services from an intersectional perspective – beyond the issue of these women’s individual health beliefs and behaviours, and rather within the broader contexts of their overall experiences with the Canadian healthcare system – experiences that are related to their immigration processes. The research also examined the issue from the perspectives of these women as rightful citizens equally entitled to the state provided services including health care and cancer screening services.

The Canada Health Act aims to ensure universal access to health services for all residents of Canada. However, many people, including recent immigrants face special challenges or barriers to accessing health care in Canada due to their lack of knowledge about existing services and unfamiliarity with the new healthcare systems and practices. Language and cultural barriers also make the services inaccessible for many immigrants who come from non-European or Western countries and lack skills in the official languages of Canada. Johnson et al. (1999) pointed out that common barriers to South Asian women’s access to breast screening programs include language difficulty, cultural beliefs, low socioeconomic status, and the lack of referral from a physician. Relatively small proportion of research that has looked at the health care related factors that impact South Asian and other ethnic minority women’s underutilization of cancer screening suggested that structural issues within the healthcare system such as, the lower proportion of females in the medical profession, besides the cultural values or health beliefs, restrict these women’s use of cancer screening. The current study particularly explored the barriers within the Canadian healthcare system, especially the structural barriers South Asian immigrant women encountered in accessing primary health care including cancer screening in Canada.

The women’s personal experiences with the Canadian healthcare system in the current study varied with their diverse socioeconomic circumstances but also reflected some systemic problems. Most women irrespective of their age and educational status were overall appreciative of the healthcare services in Canada. Women who came from rural parts of South Asia thought the Canadian healthcare system is far better than the system in South Asia because first and foremost, most of the services are ‘free’ of cost; moreover, the Canadian system is more advanced in terms of infrastructure and medical technology. A few women, who had lived in
another developed country, such as the US or UK, had somewhat different view of the Canadian healthcare system. In general, highly educated women, mostly those with past experiences of using health services in another Western country, and the women belonging to the community support group, were more conscious and critical about the system in Canada. For example, Champa had her first Pap smear test done in the US and she gave credit to the physicians in the US: “Believe me or not, physicians and nurses, everybody work more professionally in private sectors in the US, yes!” But Rose strongly contended Champa’s view, “One good thing [about Canadian health care] is that it’s same for everybody. In America it’s not same for everybody – poor people don’t get good treatment.” While most women spoke in favour of the ‘free’ public or universal health care in Canada, a few women shared their negative experiences with the Canadian healthcare system, especially in hospitals. Sury’s complaints summarized most women’s experience of services in hospitals: “You know, in hospitals things are not going right! The patients there are sometimes so sick but they’re not taking good care of them. Nobody pays ANY attention until your turn comes. Sometimes they even send you home simply giving some vitamins!” Kasturi, a young Punjabi woman, felt that she was not treated with respect and was rather neglected when she went to the emergency department in a local hospital few years back. She said she was very uncomfortable because, in her own words –

_We already have the language problem and then I feel like there’s something wrong. They are not that good with you. You feel like they treat you a bit differently. You can just feel it but it’s hard to express, you know! They don’t behave well or speak nicely with you._

On the other hand, Dahlia asserted, “even though I wear salwar-kamiz or sari and speak English with an accent I’ve never had any bad experience and had always been treated with respect everywhere I go for health care.” Most new immigrants, compared to the long time residents, did not have much exposure to or experiences with the emergency and other secondary or tertiary care in hospitals or clinics. This could be due to the fact that they were found to be relatively healthy. Overall, the participants’ experiences and perspectives provided an important understanding of the broader Canadian healthcare system and the systemic barriers inherent in it – a backdrop against which these women’s access to and experiences with the cancer screening services were critically understood.

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15 As Dr. Joan Anderson pointed out in a personal communication, theoretically everyone in Canada has access to health care because people do not pay for services at the point of care; instead heathcare cost is paid for through taxation and premiums. Therefore, universal health care is not ‘free.’
The Canadian healthcare system provides breast and cervical cancer screening through different components – the Pap tests are performed by family physicians in their offices while mammograms are done by specialized technicians and radiologists in hospitals or special clinics. But women’s access to both of these services seemed to be related in the current study because more women were using both rather than any one of these services. Women’s experiences revealed that some family doctors played important roles in initiating both Pap tests and mammograms for a number of women although in the province of British Columbia no referral is required for women aged 40 and older in order to access mammogram services. Many women were informed and recommended by their family physician about the breast cancer screening offered by the organized breast screening programs in BC. On the other hand, although Pap smear test is considered one of the most widely accessible forms of cancer screening (McDonald and Kennedy, 2007) because it is offered by physicians in their offices, many women faced barriers accessing this service from their family physicians. The following sections discuss the several problems encountered by the South Asian women in relation to their access to health care in general and cancer screening in particular in Canada.

**Availability and Quality of Primary Care**

Camellia said, “I’ve heard that many people in this country don’t even have a family physician. In that sense I’m in a better situation. At least I have one!” A report in the Toronto Sun stated that 17% of Canadians do not have a family physician (Jacobs 2010). All the women in the study, however, had a family physician, except two recently arrived immigrants. One of them, a young professional single woman, did not feel the need to have a family physician because she had her few medical needs fulfilled through occasional visits to a walk-in clinic, while the other woman, as a new immigrant, did not have a clear understanding of the concept of family physician in Canada. For the other participants, choice of a family physician was affected by such factors as physician’s gender and ethnicity, availability in a particular location or neighbourhood, availability on weekends, recommendation by friends and/or relatives, and family members attending the same physician. Despite having a family physician that had stopped practicing on weekends, one woman was using services from a walk-in-clinic doctor due to her full time work on the weekdays. A few women mentioned location of a clinic or lack of a
convenient transportation as problems or barriers to accessing health care. A couple of women said they had to depend on a male family member in order to use health care because they did not know how to drive.

The 2007 Canadian Community Health Survey found that among the people in Canada without a family physician, 1.7 million had tried but were unsuccessful at being taken on by a physician as a regular patient, while 2.4 million did not even try (Barmak 2008). A number of women, both recent and earlier immigrants, reported in the current study, based on their personal experiences that it was difficult for them to find or change a family physician because, “now doctors don’t accept new patients” and “there’s a big line up, for, especially good doctors!” A couple of women mentioned their pregnancy helped them getting accepted by their family physicians specialized in obstetrics care. But finding a physician was a real struggle for Champa, who came to Canada with her husband and an infant son. Soon after coming she became pregnant again and needed to see a specialist. She and her husband were completely on their own in their search for a family physician in Canada because they had no relatives or even any close friends to help. Neither were they familiar with any immigrant services organizations. She had quite a long story to tell about the systemic problem in Canada –

... The system over here is that first you have to go to your family doctor and then he or she is going to refer you to a specialist like gynaecologist or other ... we were calling different doctors in different places that, can we come over here and [they said] no, you cannot, you have to take an appointment. And we said, okay how long it will take and they said may be 20 days or one month to come to this place for your medical check up and you have to take an appointment. And then, you know, we were thinking that we really need a doctor at this time. So on phone or Internet we just found out where a doctor is available within that area where we were living, we called all those doctors and they said we don’t have space and we are not accepting any new patients. Then we were thinking where we can go. Then we decided that there is a walk-in clinic and they don’t need an appointment, you can just go and have your check up. So I visited my family doctor in walk-in clinic and then he first made sure that I am pregnant by taking my urine sample. And then he said okay, now you can go [to the gynaecologist] over there and she will be your regular doctor during pregnancy. That’s it!

Although some women faced challenge in finding a family physician, availability of a physician still was not as big of a problem as was receiving quality services from physicians. According to the experience and opinion of Gunj, “It’s easy to get a doctor but hard to get a good one, someone you really like or trust and depend on are not so many of that kind. Most doctors are very commercial!” Women expected empathy, more time and attention or support, less waiting time, continuity and comprehensiveness of care from their family physicians. But
many women said that they felt a rush or hurriedness and even a lack of empathy in their physicians’ attitude. They also thought that their family physicians were providing symptom based treatments rather than a comprehensive care. Chameli, along with many other women in this study, thought that presently physicians are always in a hurry trying to see more patients. She said, “I remember the days when the doctors would actually sit with you and actually ask you how are you, and would listen to you ... These days the doctor just wants to know what your pain is, okay, that’s it, go out, right?” But she definitely expected more from physicians as she insisted, “It really makes a huge difference – how the doctor walks in to the clinic and how the doctor calls out to you and that helps you a lot.” Salina also wanted more time and attention from physicians: “You know the doctors don’t look at the patient properly so you know that they are not very serious. They need to put more time into it”. The South Asian community worker, who provided interpretation help during the group interview with the women’s support group, shared her own experience and concern in this regard –

... Now a days, there is no human empathy ... Because with the seniors, they are more used to in story telling kind of a thing. So if you ask a senior a very direct question, either they will say, everything is hurting, or they will say, nothing is hurting. So there needs to be a certain relationship, right, with the senior population or even with the children, right!

However, some women also mentioned that they had a “nice doctor” who had performed a Pap smear and arranged or recommended a mammography for them. Most of the women, who did not receive any information or service regarding breast and/or cervical cancer screening from their family physician, were still more or less satisfied with the physician’s service and most of these women described themselves as healthy. Some of them had such chronic conditions as hypertension and/or diabetes which were being controlled well through medications prescribed by the physician, which is why they were satisfied. For example, Lily commented about her family physician, “Doctor is very helpful. Doctor is very nice because he gives good treatment and medicine that cures whenever I have any illnesses. He’s never in a rush like doctors in Pakistan.”

In contrast to many women’s experiences, Kasturi was among the few women who had a very caring family physician. Her South Asian female physician provided much needed support to her when she was experiencing family violence in her in-law’s house and had no friends or close relatives to share her concerns with or ask for any help. Kasturi said, “I always told my
doctor about my situation or any kind of abuse in my in-laws’ home ... And my doctor, she phoned the police. So I left in-laws’ home with the police.” Kasturi’s experience demonstrates that family physicians can be a part of a support system for immigrant women and help in their settlement and integration process. But most women, especially new immigrants participating in the study, complained that they did not receive adequate support or comprehensive care from their family physicians, who often shared the same ethnicity or cultural background. Although many women received a Pap smear test as part of their regular annual general physical examination, many did not. Four older adult recent immigrants reported a visit to a physician for a thorough health check-up (blood pressure and cholesterol profile etc.) after immigrating to Canada. But their physicians never raised the issue of a mammography or clinical breast exam or Pap smear – the later two being part of a routine yearly physical exam for women in Canada. A few women mentioned having a Pap test during their pregnancy related routine through check-up in Canada or in the US. However, not all women were screened through a Pap smear during pregnancy in Canada.

Recent immigrants were not the only women to remain uninformed about breast and cervical cancer screening by their family physicians. Some older women also mentioned a lack of initiative on their physicians’ part in this regard. A news report stated that many immigrants to Canada, as one University of Ottawa study found, suffer illnesses they do not know are treatable (such as, depression, hepatitis B, HIV and cervical cancer) and unfortunately, only a few physicians try to look for or diagnose them (Tam 2010). Dr. Kevin Pottie, a professor of family medicine at the University of Ottawa and the founder of a medical clinic for refugees at Ottawa’s Catholic Immigration Centre, commented: “Many Canadian physicians have simply not updated their medical practices to reflect the needs of the high number of their patients who are immigrants and refugees coming from Asia and Africa” (cited in Tam, 2010). This suggests that physicians need training to be sensitive not just to the cultural aspects, but to the special circumstances and diverse needs of immigrant populations, especially new arrivals.

**Long Waiting Time**

The long time period to receiving available and important health services, especially those provided by specialists, is recognized as hindering the accessibility of care in Canada.
(Romanow, 2002). As the Romanow report on access to Canadian health care insists, a lack of a single centrally coordinated waiting list by the regional or provincial authorities instead of by individual providers or institutions is at the root of the problem. South Asian immigrant women are not alone to wait in hospitals or physician’s office or for a specialist appointment, but it is difficult for some of them to understand or accept because they come from a different system. Although long waiting time in hospitals or for specialist care does not directly impact the use of a Pap smear which can be done at the family physician’s office, the long waiting time at the physician’s office might create additional barriers for women who are already pressed for time to see a doctor, especially for non-emergency or preventative care such as Pap smear.

A number of women expressed their dissatisfaction about the long wait time for visiting specialists. Ivy, a new skilled immigrant, was attracted to Canada for its reputation for a good healthcare system although after immigration it came as a shock to her: “It’s a disaster! Getting a specialist is a nightmare! Because you have to go via your family physician and wait forever!” Many other women had similar concerns and disappointment. Sydney claimed, “I like [the system in] India. In India we go to the doctor, right, and they just give us medicine or injections right away and we get better quickly. Here we have to wait like, 2 or 3 months – long waiting period in Canada!” Her neighbour, Deepa, supported her: “Yes, in India if you don’t like one doctor or specialist you can go to a second or third one. But it’s not possible here. That’s why it’s not good here.” But Juhi, who was overall very satisfied with her family physician’s service and with the Canadian healthcare system, had no complaints about waiting time: “I don’t see any problem, you know! I know they are very busy. You have to wait for your chance, right!” A few women, both recent and long time immigrants, mentioned that they tried to avoid visiting emergency services in hospitals and rather visited a walk-in clinic because they did not want to wait for long hours in the emergency. These women, however, expressed dissatisfaction about the services of walk-in clinic doctors.

A few women in the study also complained about long hours of waiting in walk-in clinics and at the family physician’s office. Dev, a 76 year-old woman with multiple chronic health problems, said that even at the family physician’s, she often had to wait very long! Her daughter explained how they were coping with the problem –

*Because there’s lots of patients and she has to get in the line to take her file out so my father*
goes to take the file out on her behalf early in the morning. My dad is doing okay. She has a lot of problem so she stays home and then goes to the doctor’s office later. They don’t take the file out [if you ask them] on the phone. You have to go personally …You can make the appointment by phone but it takes long waiting. So if you go then it’s faster, yes.

Some non-users of cancer screening mentioned lack of time due to their gendered work of care giving and housekeeping as a problem. This is compounded by the systemic problems within primary health care. For example, Henna mentioned how time stress and her double duty of both unpaid domestic work and paid work in her home daycare created a barrier, especially to accessing cancer screening services for preventative purpose –

Well, in the current situation I’d say probably I’d do a Pap test especially after hearing few women’s story of uterus cancer. Probably I’d have done but now I have problem with timing and commuting etc. Presently the timing is a big problem for me – to go to the doctor, even to take my little son to the doctor. Monday to Friday is impossible for me now.

As she recalled a recent incident –

For example, I had something pierced deep into my foot and I’m diabetic. But I couldn’t go to the doctor to get tetanus. I went a day after because there was no one at home at that time and I babysit two other kids along with my son at home. So, how could I go? … When I went on the second day, you know what happened? I went to a walk-in clinic and they made me wait there for 3 hours! My daughter took a half day off [to babysit the kids] and then she had to leave all three kids with me at the clinic to go to her work!

The long waiting time also explains why many women felt the rush during their visit or conversation with the physician. Camellia was not very happy about her family doctor’s service because –

Sometimes she’s in rush and tries to finish fast and don’t want to spend much time for listening. Sometimes she does that because she has too many patients waiting outside. She always already has a backlog. That’s what I understand. Probably she tries to see one patient every 5 minutes because a lot of times she tends to rush. But sometimes she takes more time.

And such hurriedness shown by the physician does not seem to be conducive to a prevention focused comprehensive care.

**Unfamiliarity with Existing Services**

Vissandjée, Thurston, Apale and Nahar (2007) pointed out that remaining uninformed of existing services and adapting to novel healthcare practices represent significant challenges for many recent immigrants in accessing health care in Canada. The experiences of many newly arrived immigrant women in the study also confirmed this. For example, Ivy, despite being highly
When getting urgently needed care becomes difficult due to unfamiliarity with the system, it is very likely that new immigrants would find it hard to access non-emergency services such as Pap smear or mammogram unless they have some symptoms or familiarity with the healthcare system and clear knowledge of the benefits of prevention. This is exactly what happened to Gulmohar. Despite being a healthcare professional from a South Asian country and a very health conscious person, as a new immigrant she was unfamiliar with some aspects of the Canadian healthcare system, even with the process of getting a family physician. She did not know that a Pap smear can be done by a family physician. She had assumed that she would need to go to a gynaecologist to do a Pap smear and had planned to ask for a referral from a walk-in clinic doctor, whom she unknowingly referred as her family physician during the interview. As she mentioned in a follow up email communication (May 17, 2010):

*The doctor I mentioned was not actually family doctor, he was the doctor I visited in the walk-in clinic. Now I have a family doctor. She's a Caucasian lady, guess what... during my annual check-up this year she skipped Pap test mentioning that now study shows it’s OK to do it every other year (since I had Pap test last year).*

Similarly, as a new immigrant Mollika did not know the preventative use of Pap smear and mammogram in Canada although as a practicing nurse in India, she had clear knowledge of the diagnostic use of these tests. Thus lack of understanding about how the Canadian health system operates, and lack of knowledge about the available services contributed to lower level of
participation in cancer screening for a number of recent immigrants in the study.

Sharif et al. (2000) pointed out that immigrant minorities often remain uninformed about available healthcare services and their benefits due to language and communication barriers which in turn diminish their use and access. Immigration tends to create new challenges in terms of getting oneself informed and familiarized with the existing system, including health care. Such challenges may become even more paramount for new immigrant women without literacy or education and spoken English skills, family or community support and adequate job or financial stability. For example, when Chameli came to Canada from rural Punjab, she had little education and English ability, and she was under the impression that there was no Punjabi speaking General Practitioner available in the city. When she started attending English language classes she came to know about a Punjabi speaking physician but commuting and figuring out the way to the physician’s office was a big challenge for her in the beginning: “I didn’t even know that much, so I found it really challenging – even going to a physician’s office.”

New immigrants need to settle physically, mentally and financially, and until and unless they are settled and well integrated in the new country, their health and access to health care will be negatively impacted as the experiences of most of the recently arrived participants in the study reflected. Familiarity and understanding about the Canadian systems leading to a better access to health care is generally shaped by settlement status just as Zinnia indicated: “At the beginning it’s a lot of challenges – one challenge after another! But after some time is past people settle down, right! But the first 1 or 2 years are usually very difficult.” However, as discussed earlier, length of stay and settlement status intersect with other dynamics, such as age, educational and English language skill, category of immigration and employment, and access to community and state resources to determine women’s access to health care.

**Cultural Barriers and Ethnicity/Gender Matching**

The ethnicity and/or gender matching between healthcare providers and users is often considered a useful tool for providing culturally sensitive care. But such a culturally sensitive model of healthcare service delivery not only produces stereotypes of certain cultures but also creates stereotypes about white health professionals as completely ‘insensitive’ or unaware of certain cultures while essentializing non-white service providers as the cultural ‘experts’ only fit or
capable to serve the ethnic minorities. Some of the women interviewed mentioned how physicians of their own ethnic groups were also insensitive to certain issues. On the contrary, Malati mentioned that the white female physician she often saw in absence of her regular South Asian female family doctor in the same clinic initiated her Pap-test. Ivy had a negative experience when she first went to see a physician after coming to Canada. She and her husband went to a South Asian male physician because it was her husband’s preference to go to a physician of his own nationality – someone also recommended by a community settlement support worker of the same nationality. Her first impression of that family physician was “I don’t want to come back here!” She and her husband were quite shocked and frustrated at their first visit and felt that the physician was more concerned about payment because they did not have the Medical Services Plan card in hand yet: “He told us before we entered his office that we have to pay ... he rather reminded that you have to pay before we left. We said we will pay definitely. And both the times he said, you have to pay. Both the time so that was very frustrating for us.” They also had other concerns about that physician: “But the reason we were more frustrated about is that he doesn’t give sufficient time to us and he doesn’t listen to our worries or whatever bothers us, you know, so much!” Ivy also mentioned that the same physician, while performing a thorough physical check up, ignored the issue of breast and cervical cancer screening.

Ivy was not the only one who had a bad experience with a family physician of her own ethnicity. Several women from a small South Asian community shared concerns about the potential violation of their privacy, confidentiality and personal space in the case of seeing a physician, either a male or a female, from within their ethnic community. Research on immigrant and refugee women’s health has seldom explored whether ethnic/gender matching between healthcare providers and users leads to significant long-term positive impacts on their health and access to health care (Mulvihill, Mailloux and Atkin 2001). One study by Gastaldo et al. (1998) with Muslim women in Québec found that while the women were equally divided concerning the gender of their gynecologist, the overwhelming majority (80 percent) preferred “Canadian” over “Arab” physicians (cited in Mulvihill, Mailloux and Atkin).

Most women in the current study had a female physician and showed preference for a female physicians particularly for female cancer screening, irrespective of education or class status. But the majority of these women associated this with their personal level of comfort rather
than their cultural beliefs. Chameli, a relatively young Sikh Punjabi woman and a member of the South Asian support group affirmed that Pap smear or breast exams must be done by lady physicians; “Otherwise we may have hesitations,” she felt. The South Asian community worker supported her point: “That’s a good point. So basically she is saying that if they could have more female practitioners doing this because of the cultural background – because she has been raised [in a culture], because there is a certain level of discomfort[hichkichahaat] around that.” Then I shared my critical thinking in this regard: “You know what? I have seen that even many white women also prefer lady doctors for doing this. It’s a matter of gender as well, not just culture.” Then she agreed with me: “Exactly! This is a matter of the nature [kudrat] that women would feel more comfortable with women regarding such matter.” But South Asian women’s preference for or comfort with female physicians is more often viewed in a culturalist and racialized manner because when any white woman shows such preference or does not use cancer screening services it is usually not associated with culture.

The majority of the women in this research had ethnic minority or non-white family physicians. Most women, especially those with low or no English skill, chose a family physician from their own ethnic community for language benefits and easier communication. Few elderly women did not actually choose their own family physicians and rather depended on other family members for getting a physician who spoke their language. A few women mentioned they had a female physician for themselves, while male members of the family had a male physician. But overall, the issue of gender preference for cancer screening appeared to be much more compounded by the issue of race/ethnicity, religion and age of both the care providers and receivers/women.

A couple of women in the study wished to have a white Canadian physician. Champa, a Muslim professional immigrant from Pakistan not only showed indifferent attitude about the gender of a physician but expressed interest to rather see ‘Canadian’ physicians from outside her own ethnic community:

*I think that I’m in Canada – I shouldn’t restrict myself to my own [ethnic] doctors. Yah, I’m a very progressive lady. I’d love to work with Canadians. I’d love to have those Canadian doctors but the thing is that they should have this much openness that okay, they should accept us. They should be friendly that okay, we are here and we are now the same community. We are, all of us, are Canadians. Okay, I’m now a permanent resident one day I’ll be a Canadian and as a*
Canadian I’ll not be a Pakistani or Indian or Bangladeshi or Sri Lankan, I’ll be a Canadian. So this is it!

Another professional Muslim woman from Bangladesh said, “Actually we prefer, you know, like, the female gender definitely … otherwise I’d like to see how the white doctors function [laughing] but I didn’t get a chance so far.” On the other hand, a young professional Sikh woman, who liked female physicians better for tests like a Pap smear, rather preferred non-white physicians because from her personal experience she found that ethnic minority physicians are usually ‘more sympathetic’. As she elaborated –

Well, may be the Asians are better ... maybe they are more sympathetic...So I think if it’s possible to get an Indian or ethnic, I think I’d prefer them. Now I think they have more of a sympathy...then you can understand each other and talk better, whereas the neurologist over here, I feel he talks down at me – the white guy. Because I talked to him in neurological terms and he says very basic terms – oh you mean ... normally these specialists have this ‘I’m God’ thing and they look down at you so I don’t like him that much here. But he’s good [efficient]. He detected everything properly. But I’d rather prefer, if I could have a choice, I’d rather have ethnics doctors.

Some educated women having no problem with English language preferred a physician of their own ethnic background because of a “community feeling” and expectations of empathy, comfort and support from a “cultural insider.” Bela mentioned some advantages of having a South Asian female physician. As a caregiver of a child with special need and her late elderly mother she had a lot of interactions with different physicians in and outside the South Asian community. She provided a comparison of the quality of service received from physicians in and outside her own ethnic community. She appreciated some special cultural understandings and support from the South Asian family physician –

... my family doctor understands that in my family, in our culture, what I face being a mother of a special need child and a white doctor would not be able to understand this. He or she would probably think that I just have a small family but may not understand that I have extended families and in-laws and I might have to deal with them. But my South Asian family doctor understands this. She asked me how I dealt this matter with my in-laws. She often talks to me about these and even asks me what your husband says regarding this or if you have any upsetting conversation between you. She understands these as a cultural insider. For example, my mother lived with me and she had an understanding about this – why I didn’t keep her at an old-home. So if there were needs, she told me or explained to me that your mom had this report or that because she’s my mother. She realized that. So this is the difference.

Conversely, Bela mentioned receiving faster service from other (non-South Asian) physicians –
But, in terms of service quality, if something needs to be done a doctor from outside the community would do that right away. But my South Asian doctor would say, okay, you come next week and do this later. But these people would rather say that you wait here and get it done today. This is the difference! You can get this done in both places and things are getting done properly in both places but one is more ‘reluctant’ and the other is relatively fast.

However, more equitable and accessible healthcare practices and programs including cancer screening services need to be more than simply ‘culturally appropriate’ and should be able to address the diverse circumstances and needs of South Asian immigrant women. And understanding the complex contexts of immigrant women’s lives is critical to developing such healthcare practices and programs.

**Language Barriers**

Many elderly women challenged by lack of English language skills tried to overcome the language barriers by having a family physician who could speak their language. Only one such woman, Lily, had an English speaking male family physician and she used to see him because other family members were also going to the same physician. She always had to go with her daughter or daughter in law for assistance with language. She said, “Everybody is very helpful. Only the language [is a] problem”. In fact, most of these women managed the language issue with the help of a family or community member. Only a few women seemed to be lucky to have received a free interpreter service. As Deepa said, “When I go to [a] specialist, I get interpreter, no problem ... otherwise we try to get a friend or relative who can come with us. People often have to arrange or take responsibility on their own.” Sidney said, “If we fail to make an arrangement we can’t even go! We have to cancel appointment!” As Devi pointed out, interpretation service is not always available and making an alternative arrangement is not always possible –

*If they do have interpreter available then they do give otherwise, when someone has to take, maybe one of the family members, they will let you know. But the problem is you don’t always get someone or an interpreter everywhere. We manage our best but there’s definitely a problem. We must have interpreters. It’s a big problem! Your kids can’t go with you all the time and if you don’t get any interpreter then it’s a big problem, right!*

Many women without any or sufficient English skills encountered language barriers when accessing services from specialists, technicians and staff in hospitals, laboratories and clinics. Even sometimes women with a regular family physician from their own ethnic
community mentioned having language problems when the physician was away for a vacation or other reasons and they had to see whoever was available. In such instances, as Malati, Sury and Chameli shared their experiences, a Punjabi or Urdu speaking secretary at the physician’s office often provided translation help. But Rubeena thought that she was not able to express a lot of her problems or symptoms properly in her very limited English. When she had to see another physician in absence of her regular family physician, she asked one of her daughters to write down all the symptoms in English so that she could show it to the physician. Sury had pretty good working knowledge of English and never needed any interpretation service: “I do with whatever working English skill I have.”

Although these women were able to manage most of their medical needs with limited English, they recognized that quality and effectiveness of the care was still impacted by a lack of fluency and more technical medical terminologies. As Kasturi recognized, “Sometimes we can’t really explain things in English. We know or understand but can’t explain well in English.”

Surry explained the seriousness of the problem –

*If you don’t speak very good English, then you can’t explain your disease or health problems very well. The doctor doesn’t get a good understanding of what you’re saying or what other doctor says. So interpreter services are needed there. Sometimes, they understand only 50% of what we say and they don’t get the other half. They don’t get the whole picture of our problem if there’s no interpreter. So, without an interpreter with English speaking doctors, problems may arise! ... We can’t fully explain. They only get little of what we say. If we could speak more, talk more and explain more to the doctors, they could understand better what problems we have. So, there’s problem, but what can you do!*

Chameli pointed out that communicating with physicians and the medical system can be even more challenging for new immigrants with limited English. She remembered her own experience as a new immigrant that at the beginning she faced many difficulties in hospitals where she was unable to explain herself. Even when she accompanied other newly arrived family members to hospitals and clinics she realized the language barrier was quite intense. While the South Asian community worker in the support group emphasized the importance of interpretation services:

*I think it makes sense that we are equal tax payers. Even we, immigrants, are paying the same taxes. So there needs to be language services because it’s an essential service. And I’m quite appalled that why they don’t have this essential service in different languages!*
The community support worker mentioned recently one of her clients with very limited English had an appointment for an MRI (Magnetic Resonance Imaging). Since the clinic didn’t have any interpreter and her client couldn’t afford to pay for interpretation service she had to spend a long time explaining to her client and getting her prepared about “what to expect there, what is going to happen.” The community worker strongly felt, “It should be somebody from the health system explaining that, not somebody else in the community explaining to the person, right!” This issue is reiterated in the AMSSA (The Affiliation of Multicultural Service Agencies and Societies) report (2004) which found that there is a general lack of awareness within the healthcare system across BC of the importance of language or interpreter services in removing barriers to care, hence a lack of a progressive approach to the inclusion of language services. The report also pointed out –

Healthcare systems that do not provide language services place unfair burdens on local immigrant and multicultural services agencies, many of whom are already under-resourced and under-funded, and give the responsibility squarely to volunteers within minority communities to “take care of their own.” (AMSSA 2004, 7)

South Asian immigrant women are generally not viewed as rightful citizens entitled to receive essential services such as language and interpretation help and often are blamed for their lack of English. Moreover, they are often unduly stereotyped as illiterate and lacking English skills although there are many highly skilled and educated South Asian women who speak fluent English but may often be discriminated due to the prevalent stereotype and racialization. Champa, a professional new immigrant woman, felt that she was not treated with respect by an English Canadian physician during her visit to a walk-in clinic. She became quite emotional while telling her story –

_The doctor maybe was expecting that okay, I don’t know English well may be because of my skin may be because I’m an immigrant ... So the doctor came in that room and s/he said that what is your status in Canada? And s/he asked me some other questions that were not supposed to be asked ... I noticed that s/he was asking something which is really, I mean, not relating to my medical check up. S/he behaves that I know nothing, like I know nothing!_16 Again, maybe last month I visited in the same clinic and when I was getting immunization for my baby then I asked her when she was done that can I get a ‘sunny plus’ [band aid] and she made some faces and

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16 Champa did not want to reveal the doctor’s gender identity. However, in this connection, I would like to share my own experience as a South Asian immigrant. Even though I came to Canada with a graduate level education I often felt linguistic challenges in terms of accessing health care, especially while explaining symptoms. But to my surprise I often received compliments for my English skill because, as I realize now, as a South Asian woman I was not expected to speak fluent English due to the prevalent stereotype.
then she gave it to me. What I’m saying, I’m feeling that okay, myself being an immigrant, she is behaving like this – I’m an immigrant and a burden on economy – but I’m not a burden because I’ve spent a lot of money to come over here. And they have accepted me as a skilled worker so I am going to be beneficial to this community. I am not an ignorant person. I’m a very well educated lady and I can prove and I can get better and I can give them better.

Nevertheless, most women in the study had a family physician who could speak their language, but having such a physician did not guarantee a knowledge of or involvement in cervical and/or breast cancer screening for all of these women. Although most women did not encounter a language barrier in accessing primary care, about half of the women who never used any cancer screening also lacked English language skills as well as basic literacy. Bimla pointed out that it is not just the lack of English language that creates a barrier but also a lack of knowledge or understanding of difficult biomedical terminologies: “Medical terminology is very different from workable English, right?” Even though a few women could not pronounce or recognize the English terminologies of Pap smear and mammogram, they were using one or both of these tests because luckily their physicians were proactive and more responsible for initiating those tests. It is close to impossible for women without such language skills and knowledge of cancer related medical terminologies to ask their physicians about the tests or services, even when their physicians are of the same ethnic background and speak the same language, and probably more so because there are no common terminologies for these issues in South Asian languages. In fact, increased economic independence and better access to literacy and English language training program or community based information and services related to cancer screening will likely empower these women and prepare them to be proactive in making health care and other decisions on their own.

**Beyond the Cultural and Language Barriers: Understanding the Diverse Contexts of South Asian Immigrant Women’s Lives**

Vissandjee, Thurston, Apale and Nahar (2007) argued that as a determinant of health, migration tends to pattern or shape the effects of other generally acknowledged social determinants of women’s health. But they also pointed out that the health effects of migration, especially how men and women’s diverse experiences before, after and during migration shape the relationship between migration and health still has not been explicitly elucidated in immigration and health
research. Thus the present study attempted to understand the relationships between South Asian immigrant women’s access to cancer screening services and their immigration and settlement status and general access to the Canadian healthcare system. Despite the common gender and ethnicity, South Asian immigrant women’s varied experiences of immigration, settlement and access to health care indicated that these women are a diverse group facing different and variable barriers and challenges within and outside the Canadian healthcare system. Settlement processes and statuses of the participants were indeed shaped by their category of immigration/admission, educational background, English skills, employment status and financial backup, age/generation, length of stay, previous experience of living in a western/developed country or rural area, access to community and state resources, and availability of family and other support systems.

However, there were certain commonalities in these women’s experiences as well – commonalities that reflected the structural and systemic problems in Canada. The current study placed the issue of South Asian women’s access to cancer screening within the larger contexts of immigrant women’s lives shaped by the racialized and gendered processes of their migration and settlement in Canada. Because the diverse impacts of women’s migration, integration and settlement in a new country on their health and access to health care needed to be situated within the common contexts of these women’s lives – a context shaped by, as Guruge and Khanlou (2004) pointed out, the post-migration loss of financial and social stability, racism and discrimination, and the stress of negotiation and navigation through various institutional and structural systems that are designed to serve the dominant group. In general, the women’s narratives in the present study showed how the immigration factor compounded the intersecting forms of inequities, such as gender, class, poverty, racialization and discrimination to affect women’s health and access to healthcare. Recent immigrants were generally facing financial crises due to barriers to employment within the racialized and gendered labour market in Canada. Financial and social instability, lack of support, experience of discrimination and systemic racism caused mental stress, which in turn impacted the women’s health and access to healthcare. Although many women, especially the less educated sponsored and elderly immigrants did face particular language or cultural barriers to accessing healthcare, the majority of them were able to overcome those through choosing a physician from their own ethnic community or through extracting support or social capital from their community; but most of these women received very little support from the state. Moreover, it
was the physicians’ clinical practices that seemed to be more important than the gender or ethnicity of the physicians in ensuring that the women received quality care including recommendation/information and regular reminders about cancer screening. Thus a lack of a standard practice of family physicians in terms of recommending and educating women about the importance of preventive cancer care seemed to be an important barrier to South Asian women’s access to cancer screening.

As discussed in the earlier chapter, a majority of the long time immigrants who never used or even heard about mammogram or Pap-test screening were elderly women lacking English skills and literacy even in their own language. But a number of these long time residents also were found to have used one or both of these services either because some of them had a proactive physician who took the lead to initiate preventative cancer screening, or because some of them had become well aware of the Canadian systems with the help of community service organization(s) and/or as a result of their sufficient experience of navigating through the systems over quite a long period of time, despite their lack of education or English language skills. On the other hand, many new immigrants tended to have higher priorities of dealing with the settlement challenges than to focus on preventive care such as cancer screening that does not seem to have instant benefits. Many of these recent immigrant women’s lack of familiarity with the healthcare system which was often compounded by lack of literacy or English language skills, created barriers to accessing many important existing health services – cancer screening being one of them. The older generation women coming from rural Punjab of India and Pakistan did not enjoy access to higher education and at times, to basic literacy. But they also were denied access to many settlement services, including job and language training programs, and interpreter services in clinics and hospitals in Canada. Furthermore, the gendered roles and responsibilities of immigrant women along with the challenges of immigration and settlement impacted their health as well as their access to healthcare. These structural barriers in Canada including its healthcare system, directly or indirectly influenced many South Asian women’s access to and participation in female cancer screening. The new immigrants uninformed about the systems and existing services while dealing with basic settlement issues, and women who were disempowered due to lack of education and/or isolation and lack of community support, seemed to be in the most vulnerable positions in terms of accessing cancer screening; but not due to their common ethnic or cultural backgrounds, rather the common challenges of gendered and
racialized processes of migration, settlement and encounter with the structural barriers within the healthcare system shaped their vulnerable positionalities and access to cancer screening services. As the findings of the current study implied, many immigrant women, especially elderly South Asian women, who had low or no education/literacy, and were likely to depend on other family members for immigration and settlement issues as well as for accessing healthcare, would be unlikely to be able to ask their physicians about cancer screening. And for most recent immigrant women preoccupied with the multiple gendered and racialized challenges of immigration and integration into the new systems, asking physicians about preventative use of cancer screening might be unlikely to be included in their list of priorities.

Many of the experiences shared by South Asian immigrant women in relation to their cancer screening or access to the overall healthcare system may not be unique to South Asian or other ethnic minority immigrant women. But the current research focused on the relationship of women’s health and healthcare experiences to their gendered and racialized experiences of migration and settlement in Canada – how the social determinants of health interact and intersect with women’s migration and settlement experiences which are shaped by broader immigration and integration policies. Immigrant women’s health has been linked with policies related to immigration and integration in some antiracist work, but such discussions have been completely absent in the literature on cancer screening in general and on South Asian women’s access to cancer screening in particular. Therefore, an examination of the broader discourses, policies and processes that create and sustain the social inequities for immigrants and govern the health care and clinical practices of healthcare providers will be carried out in the next chapter in order to understand South Asian immigrant women’s access to and participation in cancer screening services more fully and critically.
CHAPTER 6: UNDERSTANDING THE SOCIAL CONSTRUCTION OF SOUTH ASIAN IMMIGRANT WOMEN AS THE ‘OTHER’ THROUGH THE LENS OF INTERSECTIONALITY

Introduction

Camellia: ...But before I even get a job, I think, I feel, actually the system is not right here. Because I can easily get a job with these degrees back home or anywhere but here! Why? Because, they – I often hear that you need Canadian degree in Canada, otherwise you won’t get a job! I already have a Master’s from the US so why would I do another here! The system is flawed here!

Ivy: ... people say, oh in Canada people go through depression! This is ridiculous! Why should they go through depression? Because the society or the system somewhere is forcing them to be depressed! ... Highly skilled [immigrants have to work as] labourers ... when you are a new immigrant, if you have to face all these stuff, you know, obviously you’ll go through a depression, you know!

This chapter examines the broader forces and structures (interlocking systems of oppression) that shape the common experiences of South Asian women. The diverse personal experiences and positions of the research participants as shaped by their gender, class, age, education, immigration and settlement status and such other factors were presented in the previous two chapters (four and five). It was also shown how the South Asian women’s individual experiences of immigration and access to health care were shaped by the complex intersections of these factors. But women’s personal experiences also threw light on the broader racializing processes and the systemic barriers in the Canadian health care and other (such as, labour market and educational) institutions. Despite variations and diversity, there were certain commonalities among their experiences, and those common experiences are shaped by the systemic and structural problems within these institutions. This chapter examines how the contemporary social locations of South Asian women have been created by the histories of race, class, and gender stratification policies in Canadian society. It also explores how current socioeconomic and health policies and the larger socio-political and discursive contexts continue to shape these women’s access to and experiences with the healthcare system and specifically cancer screening services, and as well influence their agency or ability to make certain choices.
and take necessary actions in order to stay healthy and enhance their health. Rather than describing the general experiences of all participants, this chapter represents more analytical and inferential themes reflecting the racializing processes and broader systemic issues that organize the everyday life experiences and affect the health of South Asian and other ethnic minority immigrant women in Canada.

Feminist theorist Susan Wendell argued that when we view or make people ‘other,’ “we group them together as the objects of our experience instead of regarding them as subjects of experience with whom we might identify” (1996, 60). She also pointed out that we see the ‘other’ “primarily as symbolic of something else – usually, but not always, something we reject and fear and project onto them” (ibid.). According to her arguments, the notion of ‘other’ signifies unequal social relations between dominant and subordinate groups so that those who are the ‘other’ are not only different, but also inferior in the eyes of subjects or dominant groups belonging to the center of the universe as the norm, the ideal, or “paradigm of humanity” (ibid., 61). Using the lens of intersectionality, this chapter will present an antiracist analysis of how the broader systems, structures and policies affect South Asian immigrant women’s status and position as the ‘other’ in Canada and shape their access to and experiences with the healthcare system including cancer screening services. It will particularly link the research findings presented earlier with theories and literature pertinent to the historical as well as current positionings of South Asian women as shaped by the Canadian immigration and multicultural policies and neoliberal ideologies. The ways in which contemporary healthcare restructuring, informed by neoliberal discourses and policies, govern clinical practices and affect South Asian women’s participation in cancer screening will also be discussed.

As already discussed in chapter two, the concept of intersectionality means that gender, race, class and other systems of oppression co-construct each other and therefore the different dimensions of social life cannot be separated out or understood in isolation from one another. The intersectionality framework provides important tools for critically examining the intersections of race, gender, class, age, immigration, education and settlement status in the lives of South Asian women, and as well for linking the women’s subjective experiences with the larger social, economic, and political processes and discourses. Cuadraz and Uttal pointed out that in order to do an intersectional analysis, individual experiences of race, class and gender
should be examined and understood within broader contexts and social locations. This involves exploring “how social structures shape and inform the processes by which individuals as members of historically defined groups negotiate and interpret their social locations” (1999, 179, emphasis original). They also suggested that the empirical data from in-depth interviews should be placed by the researcher within the contexts of the historical experiences of the groups represented in the study as well as the material conditions organizing their individual contemporary lives. Thus the lens of intersectionality can help us view the diverse experiences of individual South Asian women as determined by their dynamic social locations (race, class, age, immigration status and so on) and at the same time explore how individual experiences are shaped by their historical and structural positions as the ‘other.’

A Legacy of South Asian Women as the ‘Other’

The growth and development of Canada as a nation state and the persistence and advancement of capitalism in the country are closely linked with its history of colonization and immigration. The Canadian state was founded through colonization, which involved the subjugation and capitalist exploitation of native people in general, and native women in particular. With the colonization of the First Nations and the early settlement of Europeans on indigenous lands, immigration policies were developed into an important tool for building the Canadian nation (Agnew 2009; Thobani 1998, 2007; Zaman 2006). Historically, Canada has always designed immigration policies in order to meet its demographic as well as economic needs. Moreover, Canada’s desire to build the country as a white nation is also evident throughout the history of its immigration policies. Either explicitly or implicitly, Canadian immigration policies have shown racial and gender biases in different ways during different phases of development in the past two centuries. The racist ideology of Canadian immigration policy prior to the Second World War was manifested directly through its attempts to prohibit the entry of non-white people while encouraging others from the “preferred nations” or “traditional sources” of Europe and America to come and settle in Canada (Agnew 2009; Thobani 2007; Zaman 2006). The Chinese Immigration Act of 1885, the Chinese Exclusion Act of 1923, the 1907 Gentlemen’s Agreement with Japan, and the Continuous Journey Stipulation of 1908 – all came into being in order to restrict and manipulate immigration from China, Japan and the Indian subcontinent. Anderson and Reimer Kirkham (1998) pointed out that through the colonization and subjugation of Aboriginal people and the explicit and/or implicit race, gender and class biases in Canada’s past and present immigration policies,
Aboriginal and immigrant women are constructed by the Canadian state as the ‘other,’ as ‘outsiders’ to the nation and as less than full citizens.

Women of color from Asia, Africa and the Caribbean historically have been subjected to the overt and covert race, gender and class based discrimination, inherent in Canadian immigration policies, both at the systemic and personal levels (Agnew 2009; Habib 2003; Zaman 2006). South Asian women remained almost absent from Canada until 1919, although immigration of their male counterparts to Canada in small numbers had started before 1904 (Das Gupta 1994; Doman 1984; Raj 1980). The arrival of a few women from India who were wives of either Sikh elites and priests or community leaders between 1910 and 1912 was rather the exception to the general situation. As the number of South Asians started to increase in British Columbia, in response to the racist sentiments of British Columbians the federal government in 1908 and 1910 passed two different pieces of legislations that required all South Asians wanting to settle in Canada to come by a continuous journey directly from the land of origin and to possess $200 each upon landing in Canada (Agnew 1996; Das Gupta 1994; Doman 1984; Raj 1980). Since there was no direct steamship service available from India to Canada, the Continuous Voyage Order effectively halted South Asian immigration for several years and prevented wives from joining their husbands. Then as a result of an agreement between the governments of India and Canada at the Imperial War Conference between 1917 and 1919, wives and children of Indians were allowed to enter Canada (Das Gupta 1994, 2000; Doman 1984; Raj 1980). But older children were not allowed to reunite with their parents in Canada, a rule that devalued the cultural practice in South Asian communities, where older children often lived with their parents up to the time of marriage (Das Gupta 2000). Moreover, the government of British Columbia passed several laws severely barring South Asians from full social, political and economic participation in the larger society until 1947 (Buchignani 1980). Up to the 1960s, women in the South Asian community were mainly unpaid family workers and housewives (Agnew 1996; Das Gupta 1994). The presence and support of these women definitely brought stability and permanence to their communities and facilitated the processes of economic and social survival and settlement in Canada. Unfortunately, these women and their contributions to their own communities and to the Canadian nation either remain invisible in the history of immigration or they gain mention only as ‘creators of ethnic communities’ and a ‘threat’ to the whiteness of Canada. While single white women from certain European countries were
encouraged to migrate to Canada during the late nineteenth and early twentieth-century, South Asian women were prohibited to enter as single or independent and were only allowed to come as wives in order to control sexual relations between South Asian men and white women, and to maintain the racial purity of the nation by creating segregated ethnic communities (Dua 2000).

South Asian and other ethnic minority men and women organized to protest and change the discriminatory immigration laws. The overtly racist contents of Canada’s immigration policies prior to the second world war were gradually removed during the post war period, especially through the introduction of Immigration Act of 1967 and establishment of an ‘objective’ and universal point system that emphasized education, training and occupational skills as the most significant criteria for selection and admission of immigrants. The fundamental shift in Canadian immigration policy from racial preference to increased emphasis on the skill and educational qualifications and the subsequent increase in the inflow of people from “non-traditional” sources in the 1950s and 1960s was due not to the generosity or benevolence of the Canadian state, but this shift was rather integral to the political and economic or trade interests of Canada (Indra 1980; Calliste 1991, 1993; Zaman 2006). The relaxation in immigration policy with the introduction of the point system and the emphasis on family reunification resulted in a “new wave” of immigrants to Canada from Asia, Africa, Latin America and the Caribbean. The increased number of female immigrants from third world countries during this period significantly altered the old pattern of disproportionately greater immigration of third world men and also changed the demographic character of the immigrant community of color in Canada. Several authors (Agnew 1996; Taylor 1991; Thobani 2000) have mentioned that while conventional theorists claim that with the introduction of point system racism disappeared from Canadian immigration policy, antiracist scholars hold that implicit racism persisted in changed forms.17 As antiracist writers have pointed out, the biases in the Immigration Act were reflected in more subtle ways

17 Green (1976) and Hawkins (1989) are examples of conventional theorists, and Abu-Laban (1999), Agnew (1996), Das Gupta (2000), Ng (1998), Thobani (2000), among others, represent antiracist scholars. The conventional theories argue that the changes came from the enlightened vision of senior bureaucrats in the immigration ministry, and thus disregard the role and resistance of local ethnic immigrants in bringing about these changes. The antiracist theories, on the other hand, attribute the removal of racist content, rather than racist intent, to pressure on the immigration bureaucracy from internal forces such as protests and lobbying by ethnic groups and from external sources and members of the international bodies, including the United Nations, International Labour Organizations, and the British Commonwealth.
through the Euro-centric definition of the heterosexual and nuclear family, through the imbalance in the number and location of immigration offices outside Canada, through the discretionary power of immigration officers, through the norm of categorizing or subsuming women as ‘dependents’ of their husbands, through the sponsorship regime, through the emphasis on proficiency in English or French, formal education, and one’s investment potential as criteria for selecting independent immigrants, and through the introduction of the categories of business-class and entrepreneur-class immigrants. All of these rules, regulations and norms reveal certain class, race and gender specific assumptions and ideologies that produce discriminatory outcomes for different groups of immigrant people.

The Immigration and Refugee Protection Act of 2001, Canada’s most recent immigration legislation, represented the first complete revision of the Immigration Act, but without any significant change to its underlying principles and assumptions about race, gender and class hierarchies. The new Act in its effort to respond to the rapidly changing needs of “Canada’s increasingly globalized economy,” also put even greater weight on attracting more “highly skilled” and “adaptable” independent immigrants and their “human capital” (Li 2003, 37). The new Act did expand the family class by including common-law and same-sex couples and some extended family members, and by increasing the age for dependent children. But it introduced another layer of class bias through imposing barriers on the sponsorship eligibility of those receiving social assistance (Habib 2003). The National Association of Women and the Law (2001) pointed out that the denial of family reunification to people on social assistance disproportionately affected immigrant single mothers because they experience an extremely high rate of poverty, and in absence of adequate childcare, either cannot find employment or cannot make enough from employment to support or sponsor their families. Although the length of sponsorship for spouses, common-law or same-sex partners and dependents aged 22 or more was reduced from ten to three years, the tightening of the implementation of sponsorship obligations was also emphasized. The Act increased the amount of financial resources that immigrants must possess to be eligible to sponsor relatives and reinforced sponsors’ accountability and responsibility for their relatives (Spitzer 2009). Having been driven by increased concerns for public security and the threat of terrorism, the new Act also focused more than ever before on control and deportation by stereotyping immigrants and refugees as ‘public threats’ and
It not only focused on control and deportation, but also overlooked many of the rights of immigrants and refugees, and ignored the obligations of the state to human rights, equity and socioeconomic integration of immigrants (Habib 2003).

In summary, the racist, gendered and capitalist exploitation of ethnic minority women inherent in Canadian immigration policies become conspicuous through the overt and covert historic injustices as well as current day systemic inequities. The gender, race and class biases built into the contemporary immigration policies affect different groups of immigrant people differently but generally sustain their inequities and exploitation in the gendered and racially hierarchical labour market in Canada. The biases and inequities in these policies also become evident in the ways racialized women are viewed and constructed as the ‘other.’ Anderson and Reimer Kirkham (1998) pointed out that through the explicit and/or implicit race, gender and class biases in Canada’s past and present immigration policies, immigrant women are constructed by the state as the ‘other.’ As Ng (1992, 1996) argued, Canada’s immigration policy is an important determinant of the unequal status of immigrant women, and the provisions in the immigration policy complement the other forms of gender and racial inequality inherent in the broader Canadian society that contribute to the multiple disadvantages and exploitation of immigrant women. The historical legacies as well as contemporary immigration policies in tandem with multicultural and neoliberal ideologies create and maintain the unequal social relations of race, gender and class, or the process of ‘othering,’ which in effect determine the health inequities prevalent in Canadian society. The histories of race, class, and gender inequities still continue shaping the identities and social locations of South Asian women in Canadian society and set up the ideological, discursive and material conditions and contexts within which these women access, experience and deal with the country’s healthcare system, including cancer screening.

A Critical Overview of the Multicultural Policy in Canada

The changed demographics of Canada due to increased migration of ethnic minority people from Asia, Africa, Latin America and the Caribbean have given it a ‘multicultural face.’ Canada is internationally celebrated as a ‘home’ of racially and culturally diverse populations, especially since the establishment of official multicultural policy in 1971. However, antiracist scholars such as, Bannerji (2000) and Thobani (2007) have argued that the policy of multiculturalism is a
continuation rather than termination of Canada’s racist/imperialist interests to marginalize non-white immigrant minorities, and as well to reestablish white supremacy, although in somewhat subtle way in the languages of ‘diversity,’ ‘plurality’ and ‘liberal democracy.’ Bannerji argued that as a nation-building device the policy facilitated the transformation of Canada from a white settler colony to a multicultural liberal-democratic society, while managing ethno-cultural diversity and maintaining capitalist exploitation in the country. As an ideological state apparatus, Bannerji insisted, multiculturalism constructs and ascribes political subjectivities and agencies for those of white/European origin as legitimate and full citizens and for non-white people as the multicultural ‘others’ who symbolically belong to the periphery or even outside of the nation. Thobani (2007) further argued that the policy has significantly contributed to the reconstitutions of white people as tolerant and respectful of difference and diversity, while non-white people have been constructed as “perpetually and irremediably monocultural, in need of being taught the virtues of tolerance and cosmopolitanism under white supervision” (148).

Fleras and Elliott (1992) stated that during the pre-1971 era, Anglo-centrism and British underpinnings of English-speaking Canada were reflected in the cultural dimensions of Canada’s political, economic and social institutions, but were most evident in the treatment of racial minorities and in the selection of immigrants on the basis of a perceived assimilability into the Anglo-Celtic mainstream. As Abu-Laban and Gabriel (2002) put it, Anglo-conformity or assimilation of minority people to British values was the building blocks of Canadian society. Fleras and Elliott maintained that several events and developments during the 1960s paved the way for the eventual abandonment of assimilation as government policy and the subsequent emergence of multiculturalism: “Pressures for change stemmed from the growing assertiveness of Canada’s Aboriginal peoples, the force of Quebecois nationalism, and increased resentment among ethnic minorities restive about their place in society” (72). The frustration and anger of Francophones during the mid 1960s – because of their exclusion from the central political institutions and symbolic order of Canadian society, and because of the economic and socio-cultural dominance of more powerful Anglophones – led to the Quiet Revolution in Quebec culminating in a demand for sovereignty (Abu-Laban and Gabriel 2002; Fleras and Elliott 1992; Hutcheon 1998). In response to the threat to national unity and ‘Canadian identity’ the Liberal government appointed a Royal Commission on Bilingualism and Biculturalism in 1963 to study and recommend solutions to these problems (Abu-Laban and Gabriel 2002; Hutcheon 1998).
commission’s report reaffirmed the priority status of Canada’s two languages and cultures, and in 1969 the Bicultural and Bilingual Act became a law (Fleras and Elliott 1992). But in 1971, in response to widespread criticisms and concerns of immigrant minorities (non-French, non-British and non-Aboriginal people) who felt that their interests and contributions had been overlooked and ignored, the federal government proclaimed a policy of multiculturalism (Abu-Laban and Gabriel 2002; Fleras and Elliott 1992). In the words of Fleras and Elliott, “Pressures from ethnic organizations and lobby groups, along with wider political developments, created a situation where government action was necessary if only to avert a further decline in public confidence and to dampen the emergent crisis in Canadian race and ethnic relations” (1992, 73). Thobani, however, maintained that embracing multiculturalism allowed Canadians to resolve “the crisis of whiteness that had emerged in the post-war era as the colonial world exploded in violence” (2007, 154). At the same time, it “facilitated a more fashionable and politically acceptable form of white supremacy” in a neo-colonial, neoliberal global era through the recognition of white people as tolerant, pluralist and racially innocent subjects, glossing over the history of overt racism and colonization (148).

While Fleras and Elliott (1992) claimed that multiculturalism advocated a restructuring of the symbolic order to incorporate all identities on an equal basis, and Abu-Laban and Gabriel (2002) acknowledged that it symbolically recognized the contributions to the nation of Canadians with non-British, non-French and non-Aboriginal origins, many antiracist scholars have expressed cynicism about the purposes and prospects of Canada’s multicultural policy. Bannerji, for example, argued that non-English and non-French people are framed as “outsider-insiders” (2002, 91) in Canada, situated only at the margins to the central problematic of the Canadian national identity – only as mediating factors between the fundamental conflict of the two founding nations – the English and the French. Thobani pointed out that despite the adoption

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18 Although the policy at the beginning opened an avenue for minority ethnic groups to foster folklore and cultural maintenance through state funding, Abu-Laban and Gabriel (2002) point out that it has gone through a number of shifts and evolutions. Due to critiques and protests of antiracist scholars and activists against the popular ‘song and dance’ version of the policy, it has become concerned with antiracism issues. But in more recent times, the authors report, the policy has also been shaped by major funding cutbacks on the one hand, and by globalization discourses as well as capitalist business or profit making motives on the other.
of multiculturalism, the definition of the nation as primarily bilingual and bicultural reproduced the racialized constructions of the British and French as its “real subjects” and non-white people as “discrete racial ethnic and cultural groups existing within its territorial border, yet outside the symbolic bounds of the nation” (2007, 148). Bannerji also claimed that multiculturalism creates and maintains the hierarchical and binary division between the core/white Canadian culture and all the other multicultures. This binary construction that puts two rival white groups together may sound too simplistic, but as Bannerji maintained, whiteness as an ideological-political category has superseded and subsumed different cultural ethos among Europeans, and has even assimilated the Italians and Ukrainians, once considered ‘ethnics’ (2000, 113). On the other hand, as Thobani reiterated, viewing all non-white immigrants primarily through the lens of cultural and linguistic difference facilitates the ideological construction of all people of color as ‘immigrants’ on the basis of their shared cultural and linguistic diversity and difference from the white nation. Thus more than a state policy or program, multiculturalism reflects an ideology – that of whiteness. Both right and left politics – liberal multiculturalists and racist nationalists, Thobani noted, share the basic assumption that minority ethnic communities are the bearers of differences, and both imagine the national space as essentially white. The formation of multicultural policy also sidestepped and delegitimized the claims of Aboriginal peoples as being merely cultural differences, while reproducing and reinforcing “the colonial erasure of Aboriginal peoples as the original presence in the country” (Thobani 2007, 144).

The astute analyses of Bannerji and Thobani make it clear that central to the discourse of multiculturalism is the ideology of whiteness or Europeanness as the hegemonic Canadian identity and core Canadian culture, against which the differences of the racialized subjects are to be understood, measured, organized and controlled. Whiteness is equated with civilization, freedom and modernity, and as an element of bonding among English and other European conquerors, while ethnic communities are imagined as tradition bound, pre-modern, and culturally backward. Through the discourse of multiculturalism, the Canadian state constructs, reduces and homogenizes peoples from many different histories, languages, cultures and politics into abstract categories of ‘the other’ – visible minorities, immigrants and ethnics, or rather deviant from white Canadians. The policy also constructs women of color as creators of ‘ethnic communities’ and nurturers of ‘traditional’ or ‘ethnic cultures’ while maintaining white women as mothers of the nation and bearers of core Canadian culture and identity. Both Bannerji and Thobani powerfully pointed out that the official discourse of
multiculturalism cherishes ‘cultural diversity’ while managing or erasing the real antagonisms created through colonialism, Eurocentrism and racism and intersecting inequalities of class and gender. A focus on culture and cultural identity without addressing power relations trivializes concepts of class, gender and racialization, and also undermines antiracist organizing and demands for social justice and equities. It is through the “culturalization of antiracist and other oppositional politics” and the “racialized ethnicization” (homogenization of visible minority people with a fixed ethnic/cultural/political identity), as Bannerji insisted, that the Canadian state maintains the appearance of a liberal democracy. In concert with these dynamics, the existing literature’s central focus on the cultural and linguistic barriers to South Asian women’s cancer screening in Canada also indicates and reinforces the “racialized ethnicization” and “culturalization of racism” through the discourse of multiculturalism. This has effectively removed the attention away from structural and systemic barriers in the Canadian healthcare, economic and political systems while attributing the problem to the culture of these ‘other’ women.

An antiracist analysis of multicultural policy shows that multicultural policy views culture as fixed and cultural/ethnic identities as unchangeable absolutes, and thus homogenizes South Asian and other minority women as the multicultural ‘others’ who belong to the margin of Canadian nation and at the bottom of the country’s labour market. Anderson and Reimer Kirkham (1998) argued that the bifurcation of the English and French as the “two founding peoples” and people of color as the “multicultural other” is at the base of the exclusion and marginalization of the latter group both within the Canadian nation and the healthcare system. While the ideological construction of immigrant women as the ‘other’ are performed through the discourses and policies of immigration and multiculturalism, the principles of multiculturalism are also integrated in many of the state institutions/organizations, including the healthcare system in order to serve or rather ‘manage’ the ‘cultural diversity’ within the Canadian nation. Despite the current debate over the success and failure of multiculturalism in Canada as well as in Europe, the ideologies of “cultural relativism,” “liberal individualism” and “celebrating diversity” inherent within this policy have clearly shaped healthcare services and clinical practices. These principles presuppose that individuals of all cultures are equally valued and have the power to be treated as Canadian citizens with equal access to health care while the structural, material and power differences among populations are neutralized or explained as merely cultural. That is why the issues of health inequities and equitable access to health care quite often
are reduced to the issue of cultural diversity and are targeted to be addressed through providing culturally sensitive care rather than through rectifying the structural and systemic inequities. Thus the discourses and policy of multiculturalism not only construct South Asian and other ethnic minority women as the ‘multicultural other’ but also create the larger institutional and discursive contexts in which healthcare service is delivered to these women viewed as the ‘other.’ The issues of healthcare service will be elaborated in a later section – “Neoliberal ideologies and healthcare reforms.” But before that I will elaborate the processes through which the immigration policy in concert with multicultural and other policies governing community services and socioeconomic integration of immigrants continue to marginalize South Asian women as second class citizens.

**The Socioeconomic Marginalization of South Asian Immigrant Women**

Before the Second World War period, women of color faced blatant exclusion from Canada as the racial and cultural ‘other’ through the racist and gendered immigration policies. Even though large numbers of ethnic minority women have entered Canada since the post World War period, mainly under the family class, their ideological construction as the ‘other,’ or as outsiders to the nation is still sustained through the immigration and other state policies and programs directed at the integration and settlement of immigrants in Canada. This imparts serious socioeconomic, political and health consequences for these women. In fact, the status of immigrant women in Canada is largely determined by the immigration category through which they enter Canada. Most South Asian and other women of color, who enter through the family class, are not assessed for their educational and other qualifications and abilities to ‘contribute’ to the Canadian economy. They are defined as ‘dependents’ in the Immigration Act and thus are ‘othered’ as burdens on state services (such as health care and language training) and as making no ‘contribution’ to Canada, in contrast to both independent or economic immigrants and non-immigrants. In fact, the sponsorship regime, or the unconditional undertaking of support for a certain period of time (three to ten years) to the Minister of Citizenship and Immigration, sustains and reinforces sponsored family class immigrant women’s socioeconomic dependency on the sponsors. Moreover, their access to social assistance and old age security, and to various state funded services, such as social housing, language and job training programs, is denied or
restricted due to their legal bonding of dependency with their sponsors (Habib 2003; Koehn, Spencer and Hwang 2010; Spitzer 2009).

Even though men may immigrate under the family class and may also be sponsored, the ideological and social practices that define men as breadwinners, heads of households and independent allow them to overcome their dependent status after they enter the country. Thus the Immigration Act, as Thobani (1999) pointed out, ideologically constructs the ‘independent’ class (of skilled and business immigrants) as masculine, while creating the family class as a feminized one. Under the Act of 1967 sponsored immigrant women were not eligible for social assistance during the 10 year sponsorship period even after they became Canadian citizens. This was changed in 2002 to reduce the period from 10 to three years, but only for spouses and common-law partners. The sponsorship system still constructs sponsored family class immigrants, especially ethnic minority elderly women, as ‘burdens,’ or less than citizens, or the ‘other.’ The post World War II immigration policies indeed provided a large number of South Asian women with opportunities to immigrate to Canada under the family class who might not be successful in meeting the point-based criteria, but at the expense of enduring a second class citizenship status and increased dependency on their sponsors. By defining the family class immigrant women as ‘dependent,’ and by “denying sponsored immigrant women autonomy and independent status once they enter the country” (Thobani 1999, 12), the Act not only reinforces their dependency and subordinate status as women but as well overlooks the contributions made by these women through paid and unpaid labour to their families, communities and the Canadian economy. The system also forces sponsors, most of whom are already Canadian citizens, to take all the

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19 Recently citizenship and immigration minister Jason Kenney declared a federal plan to issue 40% fewer visas in the coming year to foreign parents and grandparents to be allowed into Canada for family reunification (Todd 2011). Obviously the largest number of people who immigrates to Canada through family reunification comes from Asia and most women, especially the elderly, come to Canada under this category of family class. This clearly indicates that elderly immigrants are viewed as not contributing to economy and rather are seen as a drain on Canada’s social programs and services including health care. However, Charan Gill, founder and CEO of the Progressive Intercultural Community Services Society (PICS) in Surrey, pointed out that older immigrants often help and take care of young children in the extended family home so their parents can work and contribute to the economy and community. He also thought the Indo-Canadian community will be the hardest hit by the lower offshore visa targets (cited in Todd, 2011).
financial burdens and other responsibilities for the settlement and integration of sponsored family members. Many immigrants with financial insecurities, especially new immigrants and immigrant single mothers who need support from extended family members the most, are not able to sponsor and have them here in Canada. Thus broader systems such as immigration policies, shape individual’s experiences and access to state funded services and at the same time force certain immigrants, especially elderly immigrant women with lower education and English language proficiency to depend on family support and informal community resources.

In the current study, most of the participants who were sponsored immigrants reported getting settlement support and help with overcoming the language barriers from their family and community members. One participant with a graduate level education and past experience of working as a school teacher came as a sponsored family member back in early 1990s and she described how she was refused access to settlement services because of her sponsored or ‘dependent’ status:

_Actually I never went to any ESL classes. Since my elder brother sponsored us we wouldn’t get any help from them [immigrant services agencies]. My elder brother and his wife would have to help us and there was no hope of any help from the settlement services. They made it clear to us in the first visit, and then – no training, nothing! [They said] only you can come to use our computer to look for a job. But right after coming, somehow we were able to buy a computer so we, all of us, could use that. So we didn’t need to go there. But ... everything was on our own._

Bela’s experience shows how sponsored family class immigrants are constructed by immigration policy as the ‘other,’ not equally entitled to the services designed for ‘independent’ or economic class immigrants and their immediate families. Sponsorship regime may not affect all women negatively, but through the bonding of sponsorship undertaking that creates numerous legal, economic and social barriers to the sponsored women’s autonomy, many sponsored immigrant women are actually turned into ‘dependents’ of their sponsors. Sponsored older immigrants, the majority of whom come from India and China, are not only legal dependents during sponsorship when they come to Canada, they may be left financially and socially vulnerable by a combination of structural, situational and cultural factors (Koehn, Spencer and Hwang, 2010). Several intersecting barriers such as lack of knowledge about existing services on part of both the South Asian immigrant women and the community service providers, lack of childcare, transportation and autonomy hinder many of these women’s access to a few existing services. Spitzer (2009) pointed out that although the gender biases (such as lack of childcare)
that were previously more prevalent in the language training program for immigrants have been eliminated lately, the general cutbacks to language and job training programs by federal and provincial governments since 1990s have ultimately reduced the upgrading opportunities for all immigrants.

Some highly educated and professional women of color who enter as independent or skilled immigrants also face discrimination in the labour market and in broader Canadian society, particularly through the non-recognition of their educational and professional credentials. Three highly qualified professional South Asian women in the current study reflected on this serious issue of devaluation of their education and professional experience, even though they had degrees from Europe and the US. Since the 1980s, immigration of highly educated people has significantly increased to the point that the higher-education rate among immigrants is more than double that of Canadian-born residents (Todd 2011). But it is becoming harder for them to get jobs in their fields once they enter the country, as reflected in this chapter’s opening narratives of two recent South Asian skilled immigrant women who expressed frustration over a lack of jobs suitable for their skill levels. They also pointed their fingers at the systemic racism and discrimination prevalent in Canadian society that brings in highly educated and skilled men and women and then devalues and wastes their training and qualifications leading them towards downturn and poverty and a racialized position of the ‘other,’ which bears serious negative health impacts, as exemplified in the previous chapter. Champa, a newly arrived professional woman described these realities and compared the job situation for skilled immigrants in Canada with that in the US –

You will be quite surprised that even having [the experience of] 17 years of practice in my home country and working at a higher level and moving in big places there, now I have taken a course which is legal administrative assistant and which is like a clerical course for, like, the clerks who work in legal offices. And I’ve taken a start [from here] because I think it’s really hard to get work with any English Canadian lawyer at this stage ... They have to improve this system and they have to make a policy at the upper level that if the skilled workers are coming over here then Canada has to compete with the US because the US gives visa to those skilled workers who are really wanted in US and they are really getting those jobs as per their education. But people who are immigrating to Canada, they are not getting the jobs in the proper and concerned fields.20

20 A recent report in The Globe and Mail (Friesen 2011) indirectly attests to this point raised by Champa: university-educated recent immigrants (those with five years or fewer in their new countries) earn significantly less in Canada than they do in the United States, a relatively new trend which started since
Again those who are able to secure a job in Canada often do not get paid as much as their Canadian-born counterparts. Recent immigrants, especially those who are older and have low levels of education and limited ability in English or French, according to a recent report in *The Vancouver Sun*, have experienced severe pay inequities or wage drops of 30% in recent decades, and this has put them in positions worse than other Canadians at the bottom end of the job market (Todd 2011). Yet another report states that Torontonian immigrants today are earning proportionately less than their counterparts did in the 1980s: 63 cents on the dollar for men, compared with 85 cents in 1980 (Paperny 2010). Highly educated and skilled South Asian immigrant women along with other women of color experience poverty and downward class mobility resulting from deskilling, underemployment and unemployment in the gendered and racialized labour market in Canada (Dossa 2005). Opportunities for many of these skilled immigrant women to access state funded language or job training programs and to upgrade their education and skills often are restricted because of their gendered domestic and childcare responsibilities (Anderson 1996; Habib 2003; Zaman 2006). Many of them end up in low-skilled, low-paid, dead end jobs because of the financial demands of their families. Thus, the overall lower socioeconomic status of South Asian immigrant women and other women of color, that is, their status as the ‘other,’ is created and maintained by the structural barriers set by immigration policies in tandem with other discriminatory education and labour market systems in Canada, and also by the gendered ideologies and practices and their complex interactions with other socioeconomic factors and immigration/settlement status. By creating and maintaining these women’s status as the ‘other,’ the state works in favour of their exploitation by the capitalist economy and denies them equal and rightful access to social services and to the Canadian nation.

Canada has historically depended on immigrant populations and continues to bring in new immigrants for expanding its labour force and consumers – for economic development and nation building. But when it comes to supporting and providing services to new immigrants, the Canadian state does not provide adequate support for their settlement and socioeconomic integration. Rather the state imposes those responsibilities upon the individual immigrants, and

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1980. Recent research found that new Canadian male immigrants with university degrees earn about 50% less than their Canadian-born counterparts, while the gap in the U.S. is a much smaller 30%.
attributes their ‘problems’ or ‘failures’ as stemming from the cultural difference and language deficiency of its ‘others.’ In this current study, Gulmohar, a South Asian professional trying to get Canadian credentials, pointed out this paradox, the failure of the state to utilize the huge potential brought to the country:

... We know that Canada needs skilled immigrants ... [but] their training is not accepted. So I was wondering if it’s not accepted – this is human resources built from their [home] – and these resources are [wasted] – no resources actually should be wasted, it should be utilized ... So if there is any training gap – to me it’s very logical that the current system would provide to meet that – do something to bridging that gap so that these professionals brought into the mainstream are being utilized ...

Zaman (2006) pointed out that available literature indicates that immigrants’ skills are underutilized because the assessing of immigrants’ education, training and job credentials is problematic due to lack of standardized systems and absence of a due process of accreditation. However, immigrant women of color face discrimination and exploitation in the labour market and in the Canadian society as a consequence of their ‘otherness,’ which arises from their social, cultural and linguistic differences as well as their countries of origin. Thobani (1998, 1999) made a very compelling argument that the Immigration Act, with its objectives of strengthening and enriching the “cultural and social fabric” and the “bilingual character of Canada,” organized the nationalization or integration of white immigrant women as “future citizens” on the basis of their social, cultural and linguistic compatibility with the national character, all the while bordering or excluding ethnic minority women as “immigrant women” or as outsiders to the nation on the basis of their cultural, social and linguistic diversity. Dossa (2005) poignantly pointed out that channelling and limiting immigrant women into low-paying jobs and often into volunteer community service work, not only provides cheap labour for the capitalist and increasingly global market economy, but also inflicts serious harms on the dignity, agency and health of immigrant women, especially in the absence of immediate support networks and the disruption of extended-family or social ties as a consequence of migration.

**Politics of Community/Organizations and Social Capital**

Antiracist scholarship serves to critically examine the health experiences of certain marginalized communities within the broader contexts of historical, socioeconomic and other power relations, and as well to challenge the essentialist notion of community in common usage. In common
discourses and public health research, communities are often viewed as natural categories and idealized as homogenous and bounded groups of people. As Norton et al. (2002) pointed out, the term ‘community,’ especially as it is used in the contexts of community health research, represents both a real and an ideal entity. It is real because it is considered a concrete category or set of individuals delineated by physical, social, or jurisdictional boundaries. It also signifies an intangible or abstract process of organizing civil society and community development. According to the observation of Norton et al., some of the elements and meanings reflected in the definitions of community include shared values, institutions and history, shared identity and interdependency, sense of membership, common symbol systems, common needs and purposes and a commitment to meeting them. On the other hand, Bannerji’s (2000) analysis and critique of the Canadian multicultural policy problematized communities as socially constructed political categories that reflect the racial and gender politics underlying nation-building process in the country.

As Bannerji insisted, through a combination of internal (nationalism within community) and external (hegemonic state power) forces, a group of people with a common language, religion, or interests may become identified only as a stable social and political structure, totally disregarding the power relations among them (2000, 154). The community can only hold itself together on the ground of some (imagined or ideal) commonness, through erasing internal differences or inequities and maintaining a silence about issues of power, such as class, gender and patriarchy. The political and social roots of a community lie in being collectively marked out as different from the hegemonic group or norm. As such, there is an element of ‘othering’ or exclusion (which is expressed through racialization/ethnicization, homogenization and stereotyping of minority groups) in the process of community building. People who are ‘othered’ or excluded from the hegemonic group, Bannerji asserted, also bond together in a defensive move, while being confined within a political and cultural community (155). Community, then, in Bannerji’s analysis, is a power relation between racialized/ethnicized people and the state that holds the interests of hegemonic groups. In fact, communities, according to her arguments, tend to work as mini-nations – reflecting mini-hegemonies confronting and conforming to a national ideological hegemony. As such, communities represent hegemonic power relations among community members through which the existence of patriarchy, gender and class hierarchies are erased or ignored and rather viewed as divisive factors. Bannerji viewed multicultural policy as
an ideological apparatus that relies on the notion of fixed cultural boundaries and immutable ethnic differences to divide and segment the nation’s cultural and political space as well as its labour market. This, as she believed, results in fractured cultural communities that work in favour of the social organization of classes and against the formation of a class-consciousness. Thus, Bannerji noticed, both hegemonic Canadian nation-state and ethnicized ‘traditional’ communities show a remarkable similarity and convergence in hiding or erasing the hierarchies and inequalities of class and gender. Thobani (2007) further pointed out that the power differences within and among communities are swept under the broad categories of ‘immigrants,’ ‘refugees,’ and ‘visible minorities,’ while any attempt to question or reject the multiculturalist frame of homogenized ethnic communities can be mobilized to accuse ethnic ‘others’ as not respecting diversity and difference and as being racist themselves.

Resonating with Bannerji and Thobani’s points about power differences within ethnic communities, some of the women in the current study referred to the existing jealousy, lack of unity, class discrimination and exploitations within South Asian community. Bela’s experience of discrimination inside the community unmasks the internal power inequities and class based hierarchies, and challenges the multiculturalist and essentialist representation of homogenous communities. She said she never faced any interpersonal racism from “white people” but, as she proclaimed, “… the thing that shocked me most was that South Asians often treat South Asians poorly. I mean, we have much more internal discrimination.” As she elaborated her point –

*For example, Punjabi people think Bangalies are uncivilized nation! They don’t have any practical idea or education but they assume that Bangalies come from a very poor country and they are very illiterate ... okay, they have lack of knowledge. But within our own community [of Bangalies] people treat people according to their class status ... We seem to be blind [biased] to higher status people among ourselves. We judge people according to their social status ... This I think is a clear difference between the white people and us. Because when I worked with the white people, I often went to my boss’s house and had chat with her freely and the kind of closeness I had with my boss, I never felt like I’m talking to my boss! But within our community I don’t always feel comfortable because people treat their own people so bad! So it really appals me when I see this within our own community and don’t see that happening outside in the white community!*

To Bela, class discrimination, regionalism and national prejudice within the larger South Asian ethnic ‘community’ were more salient than interracial conflicts. Thobani (2007) observed that multicultural policy, in the name of promoting cultural heritage and community participation, has created within communities an elitist leadership and capitalist class who also capitalize on
notions of cultural identities and diversities glossing over the socioeconomic inequalities. They try to gain their own interests out of these political and economic opportunities. These ethnic business groups tend to take full advantage of the gendered and racially segregated labour market that creates special disadvantage for ‘visible minority’ and immigrant women in Canada. Bela shared her shocking experience of class discrimination and economic exploitation in a local South Asian store where she started working right after coming to Canada –

The first experience I had was that – the employee can’t even laugh or sit in front of the employer of the store. The lady employer had warned me beforehand that no one should dare to sit in front of her. You have to follow whatever she orders and she clearly said that we’d have the kind of relation that exists between a master and a servant back home ... I couldn’t imagine myself doing that job but it was a matter of survival. I had to have a job because I had to pay rent, cost of food although I got support from my family. But still, I just hung on to that job and when they paid my salary – they said they wouldn’t pay me hourly and instead gave me a salary – and when I got the pay-check in my hand I figured out after calculation that, given the amount of work I did, the hourly rate came into something like 2 dollars/hour while at that time the minimum wage was 7 dollars/hour! But I was still doing that job because my brothers didn’t get a job yet and I had to earn whatever I could.

Again, within a multiculturalist framework, such experiences as Bela’s might be interpreted as internal or inter-cultural conflict rather than as an issue of capitalist exploitation in a globalized market. The ideological construction of fractured cultural communities with preset cultural boundaries and rigid ethnic differences actually works in favour of the social organization of classes in a capitalist economy. And this culturalization of race and class politics impedes the formation of a class-consciousness and antiracist organizing (Bannerji 2002; Thobani 2007).

Yet again the state manipulates community service agencies through funding while the community agencies often work on behalf of the state to organize immigrant women’s labour into the lower echelon of the Canadian labour market (Ng 1998, 1996). Ivy, a newly arrived professional woman participant in the study was frustrated not only because of the depressing job situation for skilled immigrants in Canada but also because of her negative experience with a settlement services agency –

... So these settlement people, they put you in to such a situation that you are nothing better than a labourer. This is what they explain [to] you. They never tell you, okay, you keep trying – they never help you to get the job in your profession! Never! They insist they give the real picture, Canadian experience – what is Canadian experience? – To go and work in a shop or mop or do something! And then after a year you go to study and get a degree and then you become [something] – this is the total settlement program what I have seen as a sensible person.
From her own experience, Ivy was keen to figure out what Ng (1996) found from her institutional ethnographic research about the politics of community services – they do not fulfill the needs or interests of immigrant women. Neither do they help immigrant women overcome barriers in the labour market and rather work in favour of the state and capitalist economy through reproducing and maintaining a labour market stratified by gender and ethnicity.

According to Ivy’s observation of one settlement service agency –

*All the time in the workshop they said, you have to work as a labourer. You have to have Canadian experience … but they are working, trying to put you in the Wal-Mart or to the Superstore or go to work in the graveyard’s shift in the night. This is what they are having – offers! They have lot of offers – all this rubbish work! I mean they are not fighting … we’re getting so many skilled workers, why don’t we try, start somewhere to put them into the, the basic level in that area or the field, right?… It’s frustrating … – if the Service Canada is giving so much money to the settlement people – why can’t they find us jobs according to our profession or somewhere have some connections, build up connections with the ministries and work so that we get these jobs!*

Most of the women in the study were sponsored by a husband or relative and they reported getting help with settlement from their family and South Asian community members. Few women were found to have utilized information and settlement services from community organizations besides the informal help from community. For example, Champa, a newly arrived skilled immigrant, did not know of any such organizations or services while Mollika was aware of these but did not feel the need to use such services as she was rather content to get all the support from her relatives in Canada. Most of the participants in the study, irrespective of educational status or English skill, mentioned receiving information and/or material and/or moral support needed for settlement and adaptation in a new country informally through a network of relatives, friends and community members. As these women’s experiences revealed, community helps to break the isolation, particularly faced by new immigrants, and also assist those with limited or no English skills overcome language barriers. As such, South Asian community members were found to help each other and play a big role in newcomers’ settlement and integration, including finding a place to live, getting a job or locating a doctor. Such community-based relationships and networking, trust, reciprocity, social integration, participation and a sense of belonging constitute salient components as well as proxy measures of social capital (Kreuter and Lezin 2002; Vissandjee, Apale and Wieringa 2009). In a study, Wu, Schimmele and Hou (2010) found that community facilitates social integration of new immigrants by providing

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greater access to social capital through co-ethnic networks of support. Social capital, originally conceptualized by Pierre Bourdieu, is believed to play strategic function towards the goal of enhancing equitable partnerships and civil participation in the development of healthy communities and building empowering foundation in community health promotion (Kreuter and Lezin 2002; Vissandjee, Apale and Wieringa 2009).

Yet, social capital may also function as a site and source of inequitable power relations. A critical and gender based understanding of social capital, according to Vissandjee, Apale and Wieringa’s argument, should consider how social networks operate both as resources that support women’s health, well-being, and empowerment and, alternatively, as sources of control, isolation, and manipulation. Vissandjee, Apale and Wieringa insisted that social capital research and literature is largely characterized by a lack of gender and power based analysis, particularly in the context of migration, and by a more static perspective of social relations, prioritizing Euro-centric traditions, norms, and values. They further pointed out that social capital is generally regarded as a resource within cohesive communities and as a contributor to improved quality of life, and a protector against community fragmentation, violence and poverty. But such an uncritical understanding of community as well as social capital tends to idealize and romanticize the notion of community and community bonding hiding the existing over-dependency, competition, jealousy, lack of unity, class discrimination and exploitations, as Bannerji (2000) also indicated. For example, regulations placed on sponsored family class immigrants can make it difficult for them to receive social assistance and old age security, as well as limit their access to social housing and job training programs (Spitzer 2009). Sponsored or ‘dependent’ immigrants are forced to depend on family and community as a result of the structural barriers because either they do not qualify for most of the services provided to the economic class or ‘independent’ immigrants, or they face multiple intersecting barriers to accessing a few existing services. But not all women have family support or helpful relatives and/or sufficient connections within community. A number of women in the study had actually experienced abuse in the family. Juhi mentioned, “Sometimes relatives and the family is the main problem!” Depending on friends and community members may also lead to receiving inaccurate information or creating misunderstandings among friends who may not always be able to help.
While there is a widespread assumption or overestimation regarding the availability of informal support within immigrant communities in general and South Asian communities in particular, state policies actually encourage or even force immigrant women to depend on community resources, either by hindering their access to formal support (through immigration regulations) or by diminishing the few existing community services through funding cutbacks. For example, a lack of interpretation services in hospitals and clinics forces many South Asian women with official language deficiency to extract language support from family and community members. Many women suffer extreme difficulties due to a lack of support from both community and the state. With such structural barriers in place, social networks within diaspora communities may not enable women to renegotiate inequitable gender norms or other social structures. The symbolic forms of social capital or bonding alone may not always be an effective means of ensuring equitable access to resources and opportunities (Vissandjee, Apale and Wieringa 2009). But dominant assumptions about community support among immigrant populations impose a false unity among people of diverse classes, regions, religions, languages, educational levels, employment and immigration statuses, ages and generations, solely on the basis of their ethnicity or culture. Besides, the rhetoric of community as well as social capital is likely to be used by neoliberal governments to rationalize a disproportionate burden on ethnic minority immigrant community members, especially on women, to take care of themselves while cutting down social services and public resources (Armstrong 2004; Ponic 2007).

Dominant assumptions about and constructions of cultural communities as homogenous and bounded spaces may even promote ghettoization and hinder racialized immigrant women’s integration into the broader Canadian society perpetuating their ‘otherness.’ Wu, Schimmele and Hou (2010) argued in their study that a sense of belonging to or experiences of feeling out of place in Canada are key dimensions of immigrants’ adaption to and acceptance in the host country, and important indicators of their social integration. Although the introduction of multiculturalism and symbolic inclusion of ethnic groups in Canada contributed to the racial and ethno-cultural diversification of Canadian cities, as Wu, Schimmele and Hou stated, their study found that non-white immigrants still appear to concentrate in ethnic enclaves and tend to encounter greater difficulties in feeling “at home” in Canada because of their skin color, religion, ethnic status, and so forth. The study findings indicated that these ghettoized immigrants face unique challenges in their interactions with other Canadians even though they appear to adjust
over time. While there are certain benefits of living in a segregated ethnic community or neighborhood as it provides positive social capitals – a site for social interactions, source of support and trust, and feelings of comfort and inclusion contributing to greater sense of belonging, yet Wu, Schimmele and Hou cautioned that there is evidence of an overrepresentation and concentration of immigrants in low-income or poor neighbourhoods. This leads to overburdened community services in these neighbourhoods, increases immigrant people’s social isolation and creates serious consequences for their structural and social integration into the Canadian mainstream. Most recent immigrants and visible minorities encounter a “color” barrier to socioeconomic integration that most European immigrants do not (ibid.). Stunted socioeconomic mobility among highly educated recent immigrants due to discrimination and racially based inequalities in labour markets can have structural-level effects on the social integration of immigrants, as Reitz and Banerjee (2009) also observed (cited in Wu, Schimmele and Hou). While ethnic minority communities are ghettoized and homogenized as ‘pre-modern’ and ‘culturally backward’ through the multicultural discourses and discriminatory labour market practices, they are also blamed for their lack of integration and perceived in-assimilability into modern Western Canadian culture. Ethnic minority people are ‘othered’ by racializing policies on the one hand, and they are expected to take responsibility for their own assimilation or acculturation on the other. Those unable to acculturate themselves are rendered the ‘other’ and the state transfers the responsibility of integration to immigrants and their communities. Thus development of networks based upon shared identity may facilitate some level of integration and social capital but it may often be a manifestation of social exclusion from mainstream society or a blend of two (Vissandjee, Apale and Wieringa 2009). The ideological construction of South Asian and other ethnic minority women as the ‘other’ bears material and everyday life consequences for their marginalization in the labour market, spatial segregation into ethnic enclaves and exclusion from positions of power and privilege. Such systemic racism and racialization processes organize life and economic opportunities, which in turn have an influence on racialized people’s health and ability to manage episodes of illness (Anderson 1996, 2000).

Nevertheless, a greater focus on community based approaches to health promotion as a result of the recognition of the health cost of social inequities has also led to increased interests in social capital theory as a means of overcoming poor health outcomes resulting from social exclusion and marginalization. Despite the increasing significance attributed to social capital in
population and community based health research, Vissandjee, Apale and Wieringa (2009) further emphasized the need for developing a broader, gender-sensitive conceptualization of social capital and research tools that can accurately capture how social capital facilitates women’s access to empowering resources. Just as community can be a source of both support and oppression for racialized immigrant women, understanding social capital based on unity in racialized community can impart both empowering and restraining impacts on women’s health and access to quality healthcare. Overall, Vissandjee, Apale and Wieringa cautioned, “a positive relationship between social capital, women’s health and women’s empowerment initiatives cannot be guaranteed” (2009, 195). As they explained, in some contexts, high levels of social capital may enhance access to health information, may break off isolation and foster a more supportive environment leading to immigrant women’s well-being and good health. But in other contexts, women’s participation and investment in maintaining tradition and cultural norms and values may not necessarily contribute to empowering opportunities and resources for themselves or other women. These may actually enhance these women’s ‘otherness’ in Canada and hinder healthy behaviour and access to health information and quality healthcare. Therefore, Vissandjee, Apale and Wieringa suggested, “community health researchers and policy makers must contest and address policies that reinforce social inequity and marginalization as well as forms of social capital that are damaging to women’s health, autonomy, and empowerment” (195).

In examining the health issues of South Asian immigrant women, community needs to be understood and analysed as a political category in the context of the historical and current processes of racialization as well as their antiracist struggle/solidarity. The multiple dimensions and diverse realities and needs of South Asian communities should be appreciated, and homogenization and stereotypical representation of these communities should be challenged and resisted. Pam Ponic (2007) viewed community as a site for examining and understanding the interplay between broader social structures and women’s agency, the interplay that also shapes women’s health in complex ways. In the past few decades communities have received considerable attention as important locations for health promotion and there has been an increasing interest in community-based approaches to health promotion. Such a shift in focus from individual to the community resulted from an increased appreciation for the comprehensive nature of health and understanding of health behaviours determined by infrastructure, policies...
and social norms as opposed to the biomedical system’s focus on health promotion strategies that target individual health behaviour or lifestyle changes. And the fact that the complex social, economic, and historical determinants of health – employment, housing, culture, and education often tend to cluster by neighborhoods and communities, reveals the importance and justifications for community based health promotion strategies (Kreuter and Lezin 2002). Community health promotion acknowledges the important role of the communities in order to address health inequities, and design health promotion policies and actions using an equity lens and endorsing values of equity and social justice in health (Nishtar 2007). However, as Ponic emphasized, critically conceptualizing community as complex and diverse power relations rather than as a fixed category, strategizing creative ways to include marginalized, isolated, excluded women and men, and extending community support to them are key to community based health promotion.

**Multiculturalism, Neoliberal Ideologies and Healthcare Reforms**

A discussion of ‘culture’ in Canadian health discourse must be contextualized within broader socio-political discourses of multiculturalism and neoliberalism. The discourse and policy of multiculturalism put forward the liberal rhetoric of celebrating ‘cultural diversity,’ preserving the traditions and cultural differences between various ethnic groups, which are regarded unique, mutually exclusive and equal or power-neutral. The values of equality and fairness embedded in the ideology of egalitarianism in liberal democratic societies such as Canada presuppose that individuals of all cultures are equally valued and equally treated as Canadian citizens enjoying equal access to resources and health care (Tang and Browne 2008). However, this language of citizenship and equal opportunity ignores the lived realities and health experiences of many people multiply disadvantaged due to their race, gender, class, geographic location, disability, immigration status and so on (Anderson and Reimer Kirkham 1998; Tang and Browne 2008). Moreover, such rhetoric obscures more serious socioeconomic and political disparities among populations and the ways racism and unequal power relations prevent certain segments of the population from their full participation as citizens and hinder their access to healthcare. Neoliberal discourse of equality of opportunity assumes individuals as autonomous and free to access and use social and financial resources or services and take responsibility for his or her own wellbeing (Ponic 2007). Liberal egalitarianism, when applied as a professional standard of ‘equality and fairness’ in healthcare, can encourage healthcare providers to uphold the value of
equality by treating everyone the same regardless of their social locations (Tang and Browne 2008). The structural inequities and power relations deeply embedded within this system are generally ignored to the extent that those who do not benefit from the system are seen as personal failures often blamed as stemming from their backward cultures (Ponic 2007; Tang and Browne 2008).

Socioeconomic and health policies in Canada, particularly since the late 1980s, have been dominated by the ideology of neoliberalism which promotes an economic system free of government regulations or restrictions and dismantles the publicly funded services intended to bring in equity and social justice in a welfare state (Anderson 2000). This has resulted in a diminishing social welfare system and erosion of the social safety net, increasing the gap between rich and poor, and declining public health services leading to poor health status of marginalized men and women (Anderson 2000; Ponic 2007). Neoliberal ideology has also shaped healthcare reforms, a global phenomenon and a consequence of globalization, which aim to control healthcare costs through massive restructuring of healthcare services (Anderson 2000). The processes of global economic and healthcare restructuring have amplified the socioeconomic disparities and the resulting health inequities among populations. Through such discourses as ‘health care close to home’ this health service approach transfers major responsibility for care from the state to the private sector (Anderson 2000, 223). The neoliberal reform in Canada has also meant fewer hours of paid work for trained healthcare providers in the public sector and more hours of unpaid care work for women in the household or more hours in the often non-unionized third sector, such as non-profit community organizations (Armstrong 2004). In other words, the healthcare system has transferred more care from state funded hospitals to communities and private domain of home, wherein women are forced to take responsibilities for the welfare and care of family and community members (Anderson 2000; Armstrong 2004). Such demands on women without support and/or training often result in poor care of the sick and/or disabled as well as poor physical and mental health of the caregivers (Armstrong 2004; Ponic 2007). This growing care-giving responsibilities for women, has major negative consequences such as, the reduced economic opportunities or increased economic hardship especially for immigrant women of color who are largely involved in unpaid volunteer or underpaid jobs (Anderson 2000).
The Impacts of Healthcare Reform on Immigrant Women

Mulvihill, Mailloux and Atkin (2001) pointed out that the health needs of immigrant women and their access to health care have to be examined in the context of healthcare restructuring and the competition for scarce resources, especially so because healthcare reforms may have differential impacts on immigrant and refugee women as compared to the general population. Healthcare reform is one of the important contextual and environmental factors that has changed the living conditions of immigrant women and resulted in increased demands on community organizations and on women as informal or unpaid caregivers (Vissandjée et al. 2000). Immigrant women are often burdened with greater unpaid responsibilities for the care of ill, disabled or elderly relatives than non-immigrant women because of language and cultural barriers in health and home care services (Mulvihill, Mailloux and Atkin 2001). The focus on cost containment of public health services and ‘early discharge’ of patients from hospital translate into “fairly extensive healthcare services in the home upon discharge from hospital” besides the burden on women of other types of “supportive services ... such as cooking, cleaning, shopping, doing the laundry and all the other routines of everyday life” (Anderson 2000, 223). A number of women in the current study referred to this practice of ‘early discharge’ from hospitals, especially the obstetrics wards. Rose, a mother of four, recalled her experience –

When we have a baby at the hospital they just want us to go [home] within like, 6 or 8 hours! They say – oh, you’re all okay, the baby is all healthy, go home, go home! ... I got my son at like, 11:30 at night. And like, early in the morning, 4 o’clock, [the nurse] started pushing me like, you’re all okay, you should go home ... and when they came to ask me, are you having lunch here? I was so mad – I’m not here to have lunch – I’m going! And I came home before lunch. So I left hospital before 24 hours! ... Here as soon as baby comes out they put it on you! They give the baby to you and leave! And you don’t know how much I was bleeding! ... But there is a specific test for baby. So I had to take the baby and go to the lab again, like, in that condition!

After coming home, Rose had a family of five along with the newborn to take care of without any extended family support. Kamini, a young single immigrant mother of two, also shared a similar experience. Although she had received some support from her parents, she had to deal with the stress of leaving an abusive partner and recovering from a caesarean delivery. As she complained about her ‘early discharge’ from the hospital –

I wanted to stay there for a few more days. But I was sent home before one or two days. I especially wanted to stay longer during my second childbirth as I didn’t have anybody to take care at home, right! As long as I stayed in the hospital I was treated well but I wanted to stay 1 or 2 more days. But it didn’t happen although they used to keep women in hospital longer before. But I don’t know why they changed that! They send you home within 3/4days after surgery ...
They have different types of beds so you don’t have trouble getting up. But at home we have so much difficulty simply to get in and out of bed [after a surgery] ... in the past they used to help single moms a lot. I was told by a lot of single moms, even if they have a husband or mother-in-law [who is] not good [abusive] at home – they used to keep women with such problems much longer in the hospital. Even those who had normal vaginal delivery, they used to keep them for a couple of days, but now women who have surgery are sent home in 3 days!

Spitzer (2000) found that the impact of healthcare reform in hospital obstetrics wards placed a greater burden on the services delivered to minority women because of time constraints and hospital policies that limit access to nursing care and information (Cited in Mulvihill, Mailloux and Atkin 2001). Tang (1999) also pointed out that when the healthcare provider is already struggling to manage a tight schedule, spending time to find and use an interpreter can be frustrating and burdensome. Furthermore, racism can influence the attitudes of some healthcare providers toward implementing policies that aim to make health care more culturally responsive and accessible to immigrants and ethnic minority patients. Thus healthcare restructuring may have particularly adverse effects on immigrant women, especially those who face language and communication barriers, and are isolated and without the support of extended family. This results in increased marginalization and racialization of immigrant, refugee and poor women and Aboriginal peoples as the ‘other.’ As Kamini emphasized the issue again –

*If you have family support like, [a] good husband or mother in law, then it’s all right. But if someone is a single mom and have absolutely no support then I think they [state or the hospital authorities] should help you a bit. How much difference does it make for them if they keep you, or you can stay 1 or 2 more days in the hospital care!?*

Contemporary and global attempts to reorganize healthcare system, driven by the discourse of scarcity and efficiency, to make it more cost-effective, have direct implications for the everyday organization and delivery of health services (Anderson 2000; Tang 1999). Anderson et al. (1999) stressed the importance of examining the broader societal contexts that organize and shape the cultures of healthcare service rather than focusing on healthcare providers as individuals since the health care is delivered in certain social and ideological contexts. Tang and Browne (2008) emphasized that the micro-politics of health service delivery cannot be separated from the sociopolitical and historical contexts in which they occur. Tang (1999) also pointed out that decisions about dwindling resource allocation in healthcare agencies are not value-neutral; rather they reflect the dominant notions that the majority culture holds about health and healthcare. Tang and Browne found from their ethnographic study that healthcare
providers in an urban hospital often referred to their practice as ‘treating everyone the same’ including the racialized Aboriginal patients, reflecting a predominant egalitarian discourse in Canadian health care that all people are treated equally. Such discourses and assumptions hide the structural inequities and unequal power relations that shape social locations, life opportunities and everyday experiences of people coming from minority ethnic and cultural backgrounds. In fact, hospital health reform initiatives that administer standardized interactions with patients tend to conceptualize and confound “equal with equitable treatment, a formula that fails to acknowledge the heterogeneous nature and differential needs of hospital clients” (Tang and Browne 2008, 118). The ideology and practice of ‘treating everyone the same’ is not an adequate way to serve people experiencing racial discrimination and other inequities prevalent in health care and other institutions, rendering them as the ‘other’ in Canada.

Thus there appears to be a tension between the efforts to make the healthcare system more accessible to groups that have been under-served and the goals of cost containment (Anderson et al. 1999). The neoliberal rhetoric of scarcity of resources and cost control within healthcare reform initiatives was also felt and shared by a number of women participating in this study. For example, Rose shared her observation of the Canadian healthcare system: “one problem over here I’ve seen is that doctors don’t want, like, we have to pressurize them to do a test or something. They don’t want government money to be wasted, really! They want minimum tests or resources to be used.” In a climate of increasing fiscal restraints, the current context of healthcare reform in Canada is characterized by a decrease in the number of family physicians; downsizing of the social service sector; and overly burdened community-based services due to a decrease or funding cuts in hospitals as well as community-based health and social services (Dossa 2005; Ponic 2007; Tang and Browne 2008). These issues were reflected in the following conversations in a small group of South Asian women in the study:

Sury: There are more problems in hospitals now because you find fewer doctors. Doctors are not getting paid well or enough. There’s not enough funding so there’s job cuts for nurses. They are getting fewer hours. Hospitals and schools are being closed because of funding cuts. They can’t raise the [minimum wage from] 8 dollars to 10 dollars per hour! This shouldn’t happen. They cut 40% of our salary!

Devi: The MPs got a raise! Most of the money goes to their pocket. There’s no balance!
In fact, immigrants significantly contribute as tax-payers to government programs while “new immigrants contribute more in taxes and productivity than they consume in government transfers and healthcare resources” (Kinnon 1999, 41; cited in Mulvihill, Mailloux and Atkin 2001). However, as Mulvihill, Mailloux and Atkin argued, the short-term savings from the neoliberal restructuring of health care may be subsumed by the long-term costs of failing to meet current healthcare needs of significant populations. The same point was reiterated by one of the research participants, Camellia: “there’s no point if you have to reduce the service quality in attempting to reduce the cost. In the name of cost reduction they don’t do all the necessary tests in time!” Therefore, efforts should be taken, as Tang (1999) insisted, to balance efficiency and cost-effectiveness with equity, without compromising the right of all Canadians to an acceptable standard of healthcare, regardless of race, class, gender, and cultural/linguistic background.

**Liberal Individualism and Self-care**

Individualism is a central element in liberalism which advocates the idea that citizens are autonomous, rational and self-interested actors capable of making their own choices and exercising their rights and potentials, irrespective of their economic, political, historical and racial/ethnic backgrounds (Anderson 1996; Ponic 2007; Tang and Browne 2008; Varcoe, Hankivsky and Morrow 2007). As Varcoe, Hankivsky and Morrow explained, liberalism is linked to a free market economy in which each individual, independent of his or her socio-cultural position, is believed to have the same freedom to exchange goods and to access resources. This ideology has been reinforced globally by economic policies, which are driven by goals of cost containment and an ideology of individual responsibility for health assuming the individual citizen as capable of and responsible for living a good life by making the right choices (Tang and Browne). This approach results in the construction of health as an individual issue decontextualized from broader socioeconomic policies, systemic inequities and historical processes that craft the differential life opportunities and priorities and unequal access to resources and health care for different groups of people. As Varcoe, Hankivsky and Morrow also pointed out, “these ideologies run counter to understanding the complexity of women’s lives, their interrelationships with others and their environments, and the impact of those
Neoliberal approaches to health and wellness identify behavioural or genetic medical risk factors and place responsibilities for health and illnesses on the shoulders of individuals, focusing on biomedical, lifestyle, and behavioural factors. Such approaches fail to adequately recognize and redress broader health determinants and public policies pertaining to economic opportunities and poverty, housing, service provision, and political inclusion and exclusion of racialized men and women. Moreover, increasing neoliberal messages of individual responsibilization, or assuming responsibilities for one’s own health constructs health as an individual rather than a social and public policy issue. They also blame those who cannot meet their health needs as “discredited citizens” (Fiske and Browne 2006, 106), that is, the ‘other’ for their failure to make healthy ‘choices’ or to thrive in Canada’s egalitarian environment.

Personal responsibility is a predominant theme in the neoliberal state discourses of health promotion. The target of such health promotion strategies is to enable individuals to take greater control of his or her life by mobilizing resources (Anderson 1996). The concept of “self-care” or taking decisions and actions about one’s own health is an example of such health promotion approaches. Such concepts emphasize and value self-reliance and individual responsibility, which are underpinned by the liberal assumption that individuals have equal opportunity and equal access to resources (Anderson 1996; Tang 1999). But this tends to gloss over the structural constraints that may hinder a person’s ability to maintain health and manage illness. In the neoliberal discourse, health promotion is also often reduced to health education and changing lifestyles and behavioural risk factors of individuals. The focus is on the processes by which that individual can be enabled to assume greater responsibility for his or her health. But there has been more emphasis on enhancing awareness and health literacy, and motivating individuals to adopt healthy behaviours rather than on addressing race, class and power differentials leading to health inequities, or creating environments and social changes that facilitate and sustain healthy lifestyles or practices, especially for those living at the margins of the society (Anderson 1996).

Yet, critical feminist and antiracist scholars (e.g. Anderson; Dossa; Fiske and Browne; Jiwani; Morrow, Hankivsky and Varcoe; Tang and Browne, among others) have provided important critiques of the dominant neoliberal ideologies and emphasized equity, social justice and social determinants approaches to addressing women’s health issues.
A South Asian registered nurse, the daughter of a research participant who provided interpretation help during the interview with her mother, offered her insights about the problem of ‘individual responsibilization’ of health care and the lack of responsibilities on part of the state and physicians –

_When I came to Canada, originally, I noticed that doctor will say you’re due for your annual physical. [But now] even for children, never mind old people, they are not reminding you, mainly they are holding the patient responsible ... you should keep a track when you’re due and ... if I say, I need a Pap test, my doctor will do my full exam then ... But these people [pointing to her mother], they don’t know, right, with South Asian people – that’s the thing! I think that it’s the responsibility in primary care. Like, those physicians should be doing this. I don’t think that they are stressing [the issue of cancer screening] enough._

A few other participants also complained about the same problem and expected their physicians to take more responsibilities in informing and offering women cancer screening services.

The ideological, socio-political and fiscal atmosphere within which health service is delivered to South Asian and other racialized men and women is not conducive to comprehensive care for immigrant women – care which is responsive to the issues of gender discrimination, racialization and socioeconomic marginalization of these women. At best, these women are targeted as the candidates for culturally sensitive care. Even the physician payment structures that influence doctors’ priorities to treat more people within less time using fewest resources (cost commitment for the system and maximizing personal income) also lead them to provide treatment for more obvious symptoms or to provide symptom based treatment rather than a comprehensive one. Ideally, having a family doctor is supposed to ensure continuity of care as well as coordination and integration of care. Starfield (1998) insisted that primary care should focus on the person as a whole and not just on a particular disease or organ, and it must do this over the life course by creating a long-term relationship between the individual and the healthcare provider. But many South Asian women in this study complained that they were not receiving comprehensive care from their family physicians, mostly non-white doctors sharing the same ethnicity and language of the women. In an era of constrained financial resources, doctors and other healthcare providers are pressured to attend to more patients in less time using fewer resources. In Canada, most individual physicians bill the provincial government on a fee-for-service basis although each provincial medical association determines a fee schedule for all medical procedures (Galvin 1993). A fee-for-service system, although not the only model of physician payment in Canada, emphasizes volume over quality, and encourages episodic care
instead of coordinated care across providers and over a period of time (Guterman et al 2009; cited in MacAdam 2009). Therefore, it is probably no wonder that some South Asian women expressed dissatisfaction about how their doctors were not recommending preventative measures and offering only symptom based treatment, and only ‘one symptom at a time!’ Ironically, South Asian women are often stereotypically perceived as, and often blamed for, not seeking treatment unless they get sick or develop any symptoms. All these policies and structures that govern clinical practices and health promotion strategies for ethnic minority women may not necessarily enhance South Asian women’s participation in female cancer screening.

**Women’s Agency and Empowerment**

I have already discussed how the lives and identities of women of color in Canada have been historically shaped by the legacy of colonization and nation-building process through discriminatory immigration policies. Also, the lives and experiences of women of color as multicultural subjects are socially organized along the lines of gender, race and class both by state policies and ideologies within the community. An idealized and multiculturalist definition of community tends to ascribe a static notion of subjectivity, geography and culture on ethnic minority people. But Bannerji’s theorization of anti-assimilationist cultural nationalism or anti-colonial resistance within ethnic minority communities – a process she termed as “recolonization” (2000, 163) – equally seems to do injustice to the agency of ethnic minority women, and completely counters the notion of hybridity. The hybridity theory contests all claims to the stability of meaning and identity. It is characterized by ambivalent, transitory, culturally interconnected and borderline state of mind; reciprocal resentment and cooperation rather than total opposition between the colonizer and the colonized (Gandhi 1998). Although multicultural celebrations of ‘cultural diversity’ and hybridity in the metropolis hide rather more serious socioeconomic and political disparities (Gandhi), the concept of hybridity seems as important as Bannerji’s theory of “recolonization” in understanding the experiences of South Asian women as postcolonial as well as diasporic subjects, especially if we consider the fluid state of culture and identity, and the constant re/negotiations of these women within a white-dominated multicultural space.
From the analysis in the current study, South Asian women participants who shared their experiences cannot be completely separated from their long history of exclusion and racialization, and from their current racialized and stereotypical representation in Canadian health research and media. Neither can their experiences be understood without considering the structural forces that shape their everyday lives. However, these women’s narratives also have the power to show their resilience and agency in their struggles for socioeconomic and political survival and efforts to achieve a better and healthier life. While a focus on the structural contexts is important, a sole focus on structures fails to recognize women as active social agents embedded in particular lived realities that may or may not facilitate their action and health (Dossa 2004, 2005; Ponic 2007). Dossa’s work showed how immigrant women’s health is influenced by larger social, economic and political structures that shape their lives in the new country but she was careful not to construct the women as completely robbed of their human agency by structural forces. Rather she uncovered the struggles of racialized immigrant women in recuperating and redefining their own identities and rediscovering the meanings of health and well being. The lens of intersectionality along with the notion of hybridity also enables us to see how each individual or group occupies multiple dynamic social positions of simultaneous power and privilege within interlocking structures of oppression rather than viewing people according to a single static identity. An analysis of South Asian women’s experiences based on the theory of multiple and layered contexts of oppression and privilege stemming from the intersections of race, gender, socioeconomic class, religion, age, immigration status and other levels of inequities can also recognize women as active agents rather than passive victims of structural forces. Due to this approach’s emphasis on understanding the multiple, fluid and hybrid nature of identities this can prevent homogenization of these women’s experiences, and can also explain how dynamic identities or social locations affect women’s differential health status and access to healthcare.

According to the argument of Thobani (2007), lives and identities of immigrants always revolve around the discourse and politics of multiculturalism. Although Thobani noted that “[n]one have escaped its reach”, people in immigrant communities may show different levels of agency to either embrace, and/or reject or distance themselves from, and/or negotiate with, and/or resist multiculturalism: “Many immigrants have embraced their culturalization, some have rejected it, others have tried to ‘pass’ as Canadian, and yet others have sought to reframe
this culturalist discourse within an antiracist framework. All, however, have had to engage with it” (ibid., 165). Thobani’s comment portrays women as having differential levels of agency to manoeuvre around the structural conditions or systems of privilege and power. In the current study, most participants called themselves a member of the South Asian community or acknowledged their South Asian origin. They also indicated their multiple, hybrid, and often hyphenated identities in describing themselves through such self-identifications as South Asian Canadian/immigrant, Sri Lankan Canadian, South Asian Kenyan (or ‘not Canadian yet’) and Indo-Canadian. Ten women identified themselves as simply Canadian citizens and only one woman refrained from this self identifying protocol. As such, some women refused to call themselves South Asians or even rejected any hyphenated national identity. Four out of nine recent immigrants (length of stay: 1 to 5 years) identified themselves as South Asian immigrants rather than Canadian citizens. Interestingly in contrast, none of the long timers (length of stay: 7 to 27 years) called themselves immigrants. The legal status of citizenship as well as socioeconomic establishment provided them a sense of entitlement as Canadian citizens rather than immigrants. The simple practice of self-identification also showed women’s resistance to the homogenization of these women as ‘South Asian immigrants,’ which was certainly a common but not the only self- naming option.

Within the multiculturalist frame, it is white women who are viewed as the norm against which women of color are represented as the multicultural ‘other,’ who are denied full subjectivity and agency, and positioned at the edge of Canadian nation as well as the labour market. Thobani (2007) further pointed out that the racialized immigrants who should be able to constitute their own subjectivities within the discourse of antiracism (and not that of multiculturalism), are in fact encouraged or convinced to imagine themselves in the same culturalist tropes used against them by the (white) nationals, thereby coming to see themselves through the eyes of the nation. In the context of the current study, Ivy’s narratives reflected how multicultural subjects are restrained from having identities of their own choosing –

... one day they [counsellors at the settlement service agency] were saying – you have to change your name! You have to have an English name and affidavit it; otherwise your resume will be thrown into garbage! Put Peter or John or whatever! Yah, they also sent email to us. Because UBC also did a survey and it came in the papers, right! And after that, immediately we got emails – please change your names or the first name at least. It is true! It is a fact that they are telling!
But another participant, Champa, showed her determination and agency to resist racialized stereotypes: “I really want to prove here that okay, people who come from South Asian country – they are smart, intelligent, hard-working, honest, yah!” In similar ventures women of color have fought back to challenge their position as the ‘other’ and to have “names of their own choosing” (Bannerji 1995, 20). Ethnic minority men and women have organized at the community level, and participated in activism, demonstrations, petitions and lobbying to create pressure on the Canadian state to remove racial and gender biases from its immigration policies (Habib 2003). South Asian women have resisted systemic racism, and have organized community programs for self-help, self-education, support groups, employment counselling and the like (Agnew 1996; Das Gupta 1994; Zaman 2006). Through community groups, Asian, African, and Caribbean women have tried to empower middle-class and working-class immigrant women and mobilize them to fight against race, class and gender discrimination in Canada (Agnew 1996).

However, as indicated earlier, an intersectional analysis can reveal the important linkages between the larger structures and the subjective ways in which people in different social locations resist and negotiate with oppressive forces – how systems of privilege and power differently shape women’s ability to enact their agency and resist their positioning as the ‘other.’ As such individual women have distinctive abilities to make decisions and negotiate with power based on the multiple intersectional positions of privilege and oppression they occupy and move around. As the current research findings showed South Asian women’s health and well-being, their ability to take health enhancing actions and to access health care were facilitated and/or constrained by the intersecting effects of multiple factors such as age and generation, education and language skills, immigration and integration status, socioeconomic conditions in both home and host countries, rural/urban background, experience of living abroad before migration to Canada, and their involvement and connections in the community – all of which are connected to gender ideologies, historical as well as current day discrimination, broader socioeconomic and political structures and policies. These women’s experiences also revealed that educated women with good English language and communications skills or women who had lived in Canada for relatively long time and were well connected with community and community service organizations had the ability and agency to exercise more power and choices, to manipulate resources and extract necessary information and support, to demand better care from their doctors and even to change their family doctors when they were not happy with the service. For
example, during the interview with South Asian women in the support group, the counsellor mentioned how she tried to help and empower those women: “I also guide the women – write down what you want to ask your doctor because if you have it written down then you can say to the doctor that, okay, I have this many questions I want to ask. Because I know even with my own doctor that’s how it works.” Such women were also able to ask their doctors for initiating female cancer screening. On the other hand, elderly women without basic literacy or English language skills, who often had to depend on other family members for accessing healthcare, were not able to ‘ask their doctor’ or use the cancer screening services unless their physicians took a leading role to initiate those. Most new immigrants, who usually did not have any symptoms, were unfamiliar with many healthcare services including reproductive cancer screening and/or remained so busy with settlement and integration of themselves and their families that they could not explore such less urgent issues as cancer screening. Thus women’s agency and empowerment status pertaining to their health enhancing activities were shaped by their language ability, immigration and settlement status, gendered roles and family responsibilities and community involvement. In case of chronic illness management, Anderson’s (1996) research with ethnic minority immigrant women showed similar trends. She found that highly educated middle class immigrant women fluent in English were usually able or empowered enough to manage their chronic illnesses through changing jobs and gaining access to appropriate resources even when they did not receive much help from healthcare providers. On the other hand, women who were older and who didn’t speak English had fewer choices and were less mobile in the labour market and less able to access resources in the community. Women in the latter group – those who are relatively less empowered – are marginalized and ‘othered’ and even blamed or discredited for their poor health – but tend to see it as their personal lack rather than as a systemic issue, especially in an atmosphere of the neoliberal discourse of individual responsibility for health.

Anderson (1996) pointed out that the notion of “consumer empowerment,” a dominant theme within the neoliberal state discourses of health promotion and health and wellness movement, again reinforces personal responsibility for health. Within such discourse, as Anderson noted, even though there is often a recognition of “the social and economic structures that perpetuate inequity and that have a profound influence on health and wellbeing, the gaze is fixed upon the individual, and the processes by which that individual can be enabled to assume greater responsibility for his or her health” (1996, 699). But paradoxically, Anderson also noted,
the social structures that need to be changed to enable people to become empowered are overlooked:

[I]t is not entirely clear how class and power differentials will be addressed, presumably a necessity if the disenfranchised are to be empowered, nor is it clear how people who live in poverty, or have the marginal existence that a job in the lower echelons of the workforce provides, will acquire the resources to become empowered to assume greater responsibility for their health and health care (ibid.).

Patients who are unable to carry on basic communications with healthcare providers may not be able to obtain basic and accurate health information or to negotiate treatment decisions (Anderson 1996; Tang 1999). Since language and effective communication play important roles in the negotiation of treatment choices and decisions, when women are not able to communicate well with the physicians, they may feel disempowered. Elderly women without literacy and English language skills, who have to depend on family members or other people not trained in medicine or health care for communication, have little scope to show their agency, especially in relation to doctors whom they view as authoritative figures and as experts. Anderson, Blue and Lau pointed out that even when the patient and healthcare provider come from the same ethnic or linguistic background, “speaking a similar language does not guarantee communication” (1991, 110). Interactions between healthcare providers and patients cannot be isolated from the bureaucratic organizations within which they take place. Many patients feel intimidated by the bureaucratic nature of healthcare institutions and therefore hesitate to ask questions (Anderson 1996). Moreover, difference in educational status and social class hinder patient-practitioner interactions (Anderson, Blue and Lau 1991; Tang 1999). To cite an example from the current study – Chameli, a member of the South Asian women’s support group, who received necessary help from the counsellor as well as other group members, had a family physician of her own ethnic and language background; but she mentioned other issues with her doctor –

*The biggest problem is that your doctor doesn’t want to listen to you, not because of language. It’s just that even when you’re explaining to the doctors they are not able to understand what you’re saying, what your condition is, and they are not able to diagnose problems properly.*

The counsellor of that group gave her interpretation of the problem –

*My experience is that the doctors, I find that they have very little time ... because they have so many patients ... I hear from the other women too in my work ... they’d come, they ask you, okay, what’s the issue and within maybe five to seven minutes they want to leave the office, right? And they want to attend the next patient. So I think, and this is over the years I’ve seen, there was one time when the doctor would actually spend even up to half an hour, even more than that. And...*
now the time has really reduced!

As such, a person-focused doctor-patient relationship does not seem very plausible in the neoliberal environment of fiscal constraints and ‘efficiency.’ Elderly, less educated or uninformed women may find it difficult to communicate their needs to a physician, despite speaking the same language or sharing the same culture with their physician, who holds middle class or upper class status, particularly in a professional and bureaucratic setting and especially when he or she is overburdened with patients and only wants to attend to “one problem at a time.”

More educated women in the current study, such as, Camellia, a health professional herself, thought that physicians should treat or listen to women as equal partners in decision making: “Most doctors think of themselves as the pundit and they don’t think they need to listen to me [as a patient]... A few of them seldom do it.” Henna was rather looking for a balance between friendship or partnership and authority or professionalism in her relationship with the family physician:

… yes, she listens to me and gives me whatever I want because she knows that I’m informed or educated about medicine ... So, the problem is that I often think that I can control my doctor but this is probably not that good! ... It’s her responsibility to give me a reminder about the things that I need to do yearly. But she doesn’t ... I have a very good friendship with my doctor. Actually I realized this later that if you and your doctor are good friends then you lose the professionalism.

On the other hand, less educated or uneducated women of the older generation, or women coming from rural areas of South Asia usually believed in the authority and lead of the doctor. They believed that doctors as experts should advise on necessary check-up and treatments and patients should comply with those. They also believed family physicians should educate and advise women to do regular cancer screening. Thus South Asian women tended to have different expectations of what they wanted from healthcare providers, which tended to affect their utilization of cancer screening services as well. But overall, all the women, including those who used and/or initiated cancer screening, tended to resist the neoliberal discourse of self-responsibility in health care by demanding that family physicians should be more responsible or proactive in leading and ensuring their regular use of cancer screening tests as part of a comprehensive care rather than symptom based treatment.
Feminists have tried to understand, theorize and organize around how best to achieve control over their own bodies (Newman and White 2006). One of the main goals of the feminist movement in the West has been to gain control over women’s bodies and to empower women to claim their agencies over the medical professionals. Presenting an account of the women’s health movement of the 1970s, Riska (2003) pointed out that feminists revealed the male-centeredness and biases in medical knowledge, resisted victimization by medicine and demanded a cultural redefinition of women’s health and recognition of their agency in identifying gender-specific health needs and health services. Riska also provided a critique of the middle class focus of the women’s health and anti-medicalization movement, but she disregarded the white and heterosexual character of it, or how the movement ignored the experiences of women that varied according to their race, age, dis/ability and sexual orientations. For instance, when white middle class feminists fought for reproductive freedom and access to legal abortion in the 1960s, many Black women and women of color struggled to avoid forced sterilization. Nelson (2003) documented how activists and feminists of color not only challenged but restructured the mainstream women’s liberation and reproductive rights movements since the 1960s to early 1980s in the US. They shifted the white middle-class women’s sole focus on the right for legal abortion and highlighted the needs and interests of women of color to address sterilization abuse, access to affordable child-care and healthcare, and ways to raise children out of poverty. Similarly, ‘patient empowerment’ may also have different meanings to different women. But the liberal rhetoric of empowerment, choice and control over one’s own bodies tends to overgeneralize or universalize men and women’s experience while ignoring the power relations and inequities between and among them. Such discourses of patient empowerment and choice also render those unable to access resources and exercise their power and agency in so called egalitarian and multicultural clinical and other settings as the ‘other.’

While marginalized men and women draw on a range of knowledge and strategies in everyday interactions to empower themselves and negotiate social inclusion and exclusion, their agency and power often remain unrecognized (Ponic 2007). Women in this study, depending on their varied ages, interests, educational and socioeconomic opportunities, were found to be practicing different health enriching activities, such as, healthy eating, doing light exercise and yoga, walking, taking care of their mental-spiritual health and coping with stress through nurturing hobbies, praying and socializing with friends or neighbours, and raising health
consciousness through reading, research and getting involved with community health events and community organizations. Some women were also successfully managing chronic health conditions through diet, medication and regular visits to physicians. These women definitely showed different levels of agency and capabilities for making decisions about how to stay healthy, including whether or how to participate in cancer screening programs. However, their decisions and actions, particularly related to cancer screening, often seemed to be restricted due to several intersecting conditions, such as, lack of literacy and/or English skills, lack of familiarity with the Canadian healthcare system, financial and mental stress due to un/der-employment, social isolation or lack of community support, lack of extended family and childcare support. The women who initiated cancer screening services for themselves were definitely relatively ‘empowered.’ However, women who held the physicians responsible for not recommending and initiating cancer screening for them also showed ‘agency’ through challenging and countering the neoliberal ideology or discourse of individual responsibilization. They transferred the responsibility over to the healthcare system and healthcare providers. Some of the participants mentioned that their family physicians initiated cancer screening for them and were proactively managing all their health issues for them. These doctors seemed to be more sensitive and responsive to the needs and realities of these women and sensible enough to break the neoliberal standards of health service delivery. But some of these women were not aware or well-informed about these cancer screening issues even though those were performed on them. They believed the physicians are supposed to inform, explain and educate these women about these tests and processes so they can be knowledgeable and empowered. Those doctors whom the women saw as taking no responsibility or lead to either inform the patients about cancer screening or perform the tests for the women might have reflected their adherence to the neoliberal views of responsibilization and self-care. Or, they might have been constrained by the impacts of neoliberal restructuring of healthcare; but as already mentioned, this study focused on women’s perspectives and exploration of the healthcare providers’ perspectives was outside its scope.

**South Asian Immigrant Women as the ‘Other’ and Their Access to Cancer Screening**

So far I have discussed the racializing processes and broader systemic issues that organize the everyday life experiences of South Asian women along with other ethnic minority immigrant
women in Canada. The historical as well as current policies, institutionalized practices and structural inequities in Canada interact with each other to marginalize these women in both discursive and material ways to shape their health and access to health care including cancer screening services. The construction of Aboriginal and ethnic minority immigrant women as the ‘other,’ and their exclusion and marginalization within the Canadian nation and the healthcare system, as many antiracist health scholars (such as, Anderson and Reimer Kirkham 1998, Jiwani 2001, 2006; Fiske and Browne 2006) have pointed out, has profound implications on their daily lives, especially in terms of accessing and utilizing the country’s health care and other social services. The positioning of these women through the immigration, settlement and integration policies as the multicultural ‘other’ both at the lower echelon of racially and sexually segregated labour market and at the edge of Canada’s white-centred national imagery tremendously shapes their socioeconomic conditions and self-esteem that, in turn, affect their physical and mental health, as revealed through the personal experiences of many South Asian women depicted in the previous two chapters. It also impacts their opportunities and priorities in life and their access to quality services in Canada’s healthcare system, which is as “raced, classed and gendered” (Anderson and Reimer Kirkham 1998, 244) as the broader society. As the current research findings showed, for many South Asian women, especially new immigrants who arrive healthy or do not have any concerning symptoms, socioeconomic integration and success for themselves and their families (which is increasingly becoming difficult in Canada) might be a higher priority over prevention of potential female cancers.

While the neoliberal restructuring of healthcare delivery has put greater expectations upon the patient and family to assume more responsibilities for health, Tang (1999) argued that the expectation that patients will be self-reliant can influence the kinds of resources made available to them through policy decisions. For example, patients who lack proficiency in English are often expected to find their own interpreters. Similarly, in the case of women’s cancer screening, efforts have been made to educate South Asian immigrant women about the screening processes and choices through publishing brochures in Punjabi and through some community workshops and other modes of publicity in the mass media. It is assumed or expected that upon being educated in cancer screening women will be self-motivated to ask their doctors for a Pap smear and mammography. However, as found in the current study, many South Asian women, especially elderly women and women without literacy expect their doctors to inform and
ask them to do what is necessary for prevention and treatment of illnesses. The concept of “self-care” may have no significance for South Asian women with limited literacy who are often compelled to depend on family or community members for access to health care and other services. The neoliberal approach to health literacy and education campaigns conveying the message of ‘ask your doctor’ about particular tests or diseases or medicine also presupposes that everyone has the same socioeconomic opportunities (for example, transportation and childcare to enable health appointments) and priorities or that everyone has the power or language ability and biomedical knowledge to talk to their doctors about health issues. Therefore, the notion of ‘treating everyone the same’ also comes into effect. Unfortunately, South Asian women who are not able to comply with the approach of ‘self-care’ are relegated as the ‘other’ and are expected to extract social capital from within their community or at best, are targeted as the receivers of culturally sensitive care. In fact, all these processes reify their marginalization and status as the ‘other’ and negatively impact their health and access to health care along with cancer screening.

The liberal rhetoric of empowerment, choice and control over one’s own bodies tends to overgeneralize or universalize men and women’s experience while ignoring the power relations and inequities between and among them. Such discourses of patient empowerment and choice also render those unable to access resources and exercise their power and agency in so called egalitarian and multicultural clinical and other settings as the ‘other.’ But ‘patient empowerment’ may also have different meanings to different women. Drawing on critical feminist paradigms of healthcare, Anderson (1996) suggested that empowerment is an outcome of changes in fundamental structures and relations of power, including the relations between practitioners and patients, rather than in individual actions alone. She also cautioned that handing over responsibility for care to the patient (viewed as a consumer) and involving all the patients as decision-makers in matters pertaining to health, irrespective of their unequal socioeconomic, political, cultural and historical positions, should not be equated with ‘empowerment.’ Such notion of empowerment embedded in the neoliberal ideology of individualism provides a rationale for shifting responsibilities to people who are least able to assume such liabilities and for victimizing or blaming the victims (Anderson 1996; Fiske and Browne 2006; Ponic 2007). Many South Asian women, especially the older generation, have lack of literacy not only in English but also in their own language because of gender barriers to accessing education. Publishing pamphlets or brochures in Punjabi will fail to create health literacy among these
women. Elderly women with limited literacy cannot be empowered without improving their basic education and literacy skills and sources of secured income. As a concerned and observant participant with a background and experience in health care in a South Asian country, Camellia also pointed out the limited effectiveness of such health literacy approaches in reaching South Asian women of diverse language and educational backgrounds –… I doubt that the leaflets or other stuff provided by the system actually can reach South Asian, especially Bangali women. Even if they do make it to the hands of these women, how many women can actually read and understand those? I don’t know! And can they really fathom the significance or seriousness of the issue [of cancer screening]? I don’t think so. I think either they don’t understand or nobody really helps them to understand. Especially, within the healthcare system, in hospitals, the doctors or the nurses – nobody talks to the women to make them realize that this is serious and you got to do it regularly. I don’t think anybody takes that time to talk about these to the women.

Anderson (1996) insisted that knowledge or awareness alone does not determine illness management or healthy behaviour per se. She found that even when women were knowledgeable, the material circumstances of their lives profoundly influenced their ability to manage a chronic illness. Findings of the current study concerning the situations of new immigrants also showed congruence with Anderson’s findings. Most of the new immigrants in this study were highly educated and had knowledge of Pap smear and mammogram but not all of them were using one or both of these services due to lack of familiarity with the Canadian health system or lack of perceived importance or priority of this issue compared to more pressing needs such as, finding a good job, getting settled, managing paid work with household and childcare work, among others. Some of these women also pointed at the policy and systemic issues that fail to help new immigrants’ economic and social integration and negatively impact their health. As Vissandjee, Apale and Wieringa (2009) pointed out, for recent immigrants, empowerment may involve gaining new opportunities as rightful citizens; but skilled and educated women’s social and financial autonomy is arrested due to un/der-employment and financial downturn.

The Canadian healthcare system which is geared toward serving people who have access to resources and knowledge in western healthcare, has also traditionally excluded ethno-cultural minorities from decision-making and some professional care giving roles (Anderson 1996). Very few racialized men and women hold positions of authority in healthcare or are involved in policy making; although many are involved in healthcare delivery, they are concentrated in lower
echelons and non-professional ranks (Anderson 1996; Anderson and Reimer Kirkham 1998). The healthcare system is organized in a way that maintains hierarchy through racialization of workforce and through lack of accreditation of foreign doctors and health professionals. Gulmohar, a South Asian health professional struggling to be accepted within the Canadian healthcare system, pointed out this problem –

*The way the healthcare system operates here, like, somehow the system is not allowing the absorption of the immigrant doctors and other professionals. So I think the – both provincial and federal government should figure out something that how to assimilate them so that if the immigrant doctors’ experience is not acceptable they should be given a chance to get a good experience.*

Unfortunately the Canadian government has done very little to ‘reskill’ or integrate the immigrant health professionals despite immense research and studies revealing the ‘deskilling’ and downward mobility of these highly skilled people in Canadian labour market and society (Spitzer 2009; Zaman 2006). Foreign medical graduates, even if they are able to retrain themselves and pass the licensing examination, which is a costly process both in terms of money and time, are often discriminated against while competing with Canadian students for the limited number of placements for a two to six year residency; hence only an estimated five percent of foreign trained physicians are currently practicing medicine in Canada, despite some special programs and opportunities created for these professionals in some provinces (Bauder 2003; cited in Spitzer 2009, 146). However, through the discourse of multiculturalism and culturally sensitive care, immigrant or ethnic minority healthcare and other service providers are essentialized and ‘othered’ as the cultural ‘experts’, only fit to serve the minority people, or the multicultural ‘others’. But as some of the women participants mentioned, some of their doctors coming from the same cultural background were quite ‘insensitive’ to their needs. In fact, these doctors, once accepted within the Canadian healthcare system, also work under the same neoliberal atmosphere of cost containment and ideologies of individualism and self care, and they probably try hard to assimilate themselves within the new system. But the neoliberal multiculturalist and essentialist focus on culture removes our attention from the structural hierarchies created through racist, gendered and classist immigration policies, racialization and ‘othering’ of South Asian and other ethnic minority women through lack of accreditation of their education, skills and job experience outside Canada, and racialization and feminization of poverty leading to serious health inequities.
Health promotion strategies that aim to educate South Asian women on cancer screening through health literacy programs, or health research that tries to measure the level of their acculturation or to understand only the cultural barriers to cancer screening, and clinical practices that try to ensure equitable care simply through providing culturally sensitive care – all fail to grasp the struggles of new immigrant women, and the challenges of elderly women within their own communities and as well within Canadian institutions including healthcare. The realities that many South Asian women have to negotiate on an everyday basis include un/der/employment, physical, mental and financial stress, lack of childcare and extended family support, lack of familiarity with the system, language barrier and others. These practicalities impart significant impacts on women’s daily decisions and practices pertaining to the health of these women and their families. These issues must be acknowledged and addressed in different socioeconomic and health policies and clinical practices to ensure their better access to cancer screening services. The indiscriminate or standardized neoliberal message of self-reliance/-care, the public health policy’s focus on increasing health literacy and the essentialist multicultural approach to provide culturally sensitive care through producing pamphlets in Punjabi will not suffice. All the policies and structures that govern clinical practices and health promotion strategies for ethnic minority women may not necessarily enhance South Asian women’s participation in female cancer screening. In summary, keeping the systemic injustices and structural inequities unchanged will not ensure equitable access to quality health care for South Asian and other ethnic minority women in Canada. Their status as the ‘other’ at the margin of the socioeconomic, ideological and political terrain of the state has to be countered.
CHAPTER 7: CONCLUSIONS, DISCUSSIONS, AND IMPLICATIONS

Introduction

This study aimed to understand South Asian immigrant women’s access to and experiences with breast and cervical cancer screening services in the larger contexts of their life circumstances and their overall experiences with the Canadian healthcare system as shaped by their experiences of migration, resettlement and integration in Canada. Additionally, it intended to uncover the ways in which their use or lack of use of these services is affected by the broader systems, structures and policies that shape the everyday life experiences of these women. I conducted a qualitative feminist study informed by a social constructionist epistemology and antiracist theoretical frameworks. Data generated through in-depth interviews were organized, analysed and interpreted in light of the research questions as well as with the help of antiracist and intersectionality theoretical perspectives. In this final chapter I will discuss the main findings and arguments of the study in relation to the research objectives and questions. This work however, is not devoid of some limitations, which will be pointed out in the next section. I will then reflect on the possibilities of future research in this area as well as on the broader theoretical, methodological and practical implications of the current research. The chapter as well as the thesis ends with some recommendations for improving South Asian women’s equitable access to cancer screening and other healthcare services in Canada.

A Review of the Key Findings and Analysis

All the important research findings based on my analysis of the data in relation to the particular questions that guided this study will be revisited in this section. The first research question was: “What are the patterns and extents of South Asian immigrant women’s engagements with breast and cervical health, and prevention and screening of breast and/or cervical cancers?” Another related question was: “What shapes these women’s use or lack of use of the breast and cervical cancer screening processes?” The findings related to these questions have been described in chapter four. The majority of the users of cancer screening services among the South Asian women in the study were using both Pap smears and mammogram whereas a small number of...
women were using only one rather than both of the tests. A large number of the women used cancer screening tests for the preventative purpose compared to a few women who used either or both of the tests due to some concerns or a family history of breast and/or cervical cancer. Less than a quarter of the total number of women (N=31) had clinical breast exams done by their physicians in Canada. A few more women mentioned having a breast self-exam at least occasionally. While the majority of the women who had done CBE and/or BSE also had a mammography done in Canada, they had also experienced some symptoms or concerns about their breast health. A couple of women who were not using mammograms and/or Pap smears in Canada were somewhat aware of their breast health and often practiced a self-exam, though not regularly and probably not very accurately, to check for any palpable lumps in breasts. Only two women in the study had been involved in all the breast health detection and screening processes as well as cervical cancer screening. Both of them were under the age of 40 and had suspected some problem in their breasts, but were using the Pap test for prevention of future concerns.

Younger women generally tended to be more educated, knowledgeable of reproductive cancers, and users of cancer screening compared to the older women in the study. Elderly women who were least educated were using either both or none of the services depending on their physicians’ involvement and practices regarding the issue. Overall, there was a greater level of use of cancer screening among women with the least or no education than among women with the highest level of education, most of whom had also recently arrived in Canada. On the other hand, the majority of the women, who were using the services, including the elderly with limited education and English language skills, had lived in Canada for a longer period of time. Women’s understanding or knowledge of cancer screening did not guarantee use of the services, especially for recent immigrants whereas some of the elderly women who were using the services did not have a clear understanding. Thus women’s age, immigration, educational and generational status, not/having a family history or symptoms seemed to have impacted their use or lack of use of cancer screening services. But women’s demographic status and personal concerns and beliefs regarding cancer prevention intersected in complex ways with various other social, systemic and structural issues in shaping their actual utilization of cancer screening services – issues including women’s access to community resources and services, level of socioeconomic integration and knowledge about the Canadian healthcare system, gender roles and responsibilities, not/having a recommendation from physicians, and the role of physicians in providing cancer screening and
other care. Receiving or not receiving a recommendation from physicians played a very important role because physicians initiated and managed the screening processes for the majority of the users while most of the non-users were never informed or recommended by their physicians to do the tests. Women’s varied levels of participation in cancer screening as shaped by the interactions among women’s personal/demographic issues and the broader structural and systemic factors is depicted in the following figure.

Figure 7.1: Women’s Participation in Cancer Screening and the Intersections among Personal and Structural Issues

<table>
<thead>
<tr>
<th>Women’s personal/demographic status: older, lacking literacy/English skills, recent immigrants, healthier/no symptoms</th>
<th>Women’s personal/demographic status: younger, educated, long time residents, having symptoms/family history of reproductive cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less/lack of use</td>
<td>More use</td>
</tr>
<tr>
<td>Reproductive Cancer Screening Services</td>
<td></td>
</tr>
</tbody>
</table>

| Systemic/structural issues: not receiving physician recommendation, limited community involvement, more dependence and limited ability to ask physicians, more burdened with gendered/family responsibilities and time constraints | Systemic/structural issues: receiving physician recommendation/regular reminder, greater community involvement, more empowered and better able to ask physicians, less burdened with gendered/family responsibilities and time constraints |
However, the complexity and intersections of the dynamic factors—individual, social and structural—that influenced women’s participation in cancer screening seemed to be one of the distinctive features of the current findings. Preference for female physicians and the importance of physician recommendation are common findings in the literature on South Asian women’s cancer screening; but the current research findings showed that physician practices including recommendations were more important than the gender or ethnicity of the physician because having a female physician did not ensure having cancer screening for all the women while many of the women with a male physician were receiving the tests. Moreover, none of the non-users of the tests, who had a male physician, thought that the gender of their physicians was the problem. Most women, however, expressed or anticipated an increased level of comfort with a female physician because of common gender rather than for a cultural or religious ground.

Among the various intersecting factors that shaped women’s various levels of utilization of cancer screening services, a couple of issues seemed to have structural or systemic resonance—the gendered and racialized experiences of migration and settlement, and the experiences with primary care influenced by differential physician practices. These were elaborated in chapter five because I wanted to situate the issue of South Asian women’s cancer screening within the broader contexts of their migration, settlement, gender and health status, and their general access to and overall experiences with the Canadian healthcare system. This was reflected in the third research question: “What are these women’s experiences with the healthcare system in general and the cancer screening processes in particular and how are their experiences related to immigration processes?” Thus chapter five dealt with both the second, and especially the third research questions stated above. While participants’ descriptions about the challenges of migration and settlement— isolation, loss of family ties, support and social status, language barriers, systemic racism and discrimination, and financial insecurity and stress caused by un/der/employment—resonated with the existing literature on experiences of ethnic minority immigrant women in Canada, these had not been previously connected to South Asian women’s experiences of cancer screening. The complex relationships between migration, health and access to health care were brought to the center of current analysis. The analysis showed that several intersecting dynamics, such as, gender, category of admission, age, financial in/stability, education level and English language skills, access to employment, settlement services and other
resources not only shaped women’s diverse experiences of immigration and integration, but also facilitated or challenged their access to cancer screening services and the Canadian healthcare system in general.

The current study’s unique approach and exploration of the broader contexts of immigrant women’s everyday lives and their general experiences with primary care in Canada also shed light on the structural and systemic problems or barriers. Women’s narratives revealed that gendered ideologies and duties of parenting most often without the support of extended family in Canada, challenges of finding childcare, lack of adequate transportation and lack of literacy and autonomy did not allow many of them to focus on preventative care or sometimes, even on personal care. Women’s narratives showed how the immigration factor compounded the intersecting forms of inequities, such as gender, class, poverty, racialization and discrimination to affect women’s health and access to health care. Most new immigrant women who faced financial stress due to under/employment and/or lack of family and community supports, along with the elderly women who were likely to depend on family members for immigration and settlement issues as well as for accessing health care due to lack of basic literacy and English language skills, seemed to be in most vulnerable positions in terms of accessing cancer preventive health care. Such positionalities not only tended to pose unique health challenges for these women but also made it difficult for them to use preventive care, such as, reproductive cancer screening, not because of their common ethnic or cultural backgrounds, but due to their common gendered and racialized experiences of migration and settlement shaped by several socioeconomic and structural factors. The participants’ experiences showed that their access to cancer screening was related to their access to the broader Canadian healthcare system, and especially to the systemic barriers inherent in the primary care within which the cancer screening services are provided. The current data showed that South Asian women encountered more than cultural and language barriers in accessing cancer screening services. Many recent immigrants were uninformed about existing services such as Pap smear and mammogram and faced barriers in accessing health care in Canada, especially preventive care which is usually viewed as non-urgent. Women expected from their family physicians more empathy, quality time, attention and support, continuity and comprehensiveness of care, and less waiting time when needing care from healthcare providers including family physicians. But many women complained that their physicians, despite sharing the gender and/or ethnicity and language spoken, often ignored many
of their concerns or only treated immediate symptoms rather than providing comprehensive care to ensure their overall wellbeing.

These findings inspired further exploration of the broader socioeconomic and healthcare policies, structures, discourses and processes that shaped physician practices as well as South Asian women’s socioeconomic and structural positions in Canada and their relationships or experiences with physicians, health care and other service providers. This was a good fit to my final research question that asked: “How do the broader systems, structures and policies shape South Asian immigrant women’s participation in and access to cancer screening services?” This question was addressed in chapter six and this led to deeper insights about how South Asian women’s access to healthcare system including the cancer screening processes was linked with their experiences of migration and resettlement in a gendered, racialized and classed as well as a multicultural and neoliberal society, and with their historically structural position as the ‘other’ in Canada. I undertook an intersectional analysis in order to uncover the larger and interlocking political, socioeconomic and healthcare policies, processes and discourses through which these women’s use of cancer screening services might be influenced. I examined the historical and current constructions and positionings of South Asian immigrant women as the ‘other,’ particularly through the Canadian immigration and multicultural policies and neoliberal ideologies. I also analyzed the ways in which the neoliberal discourses and policies govern social and community services, contemporary healthcare restructuring and clinical practices, and affect South Asian women’s participation not only in reproductive cancer screening but also in the Canadian healthcare system in general. All the women in the study might not have experienced personal racism or discrimination in their interaction with health care and other service providers (although some of them did); but the historical and current positioning of these women as the ‘other,’ both at the lower ranks of racially and sexually segregated labour market and at the margin of Canada’s white-centred national imagery, seemed to tremendously shape their socioeconomic conditions, self-esteem, opportunities and priorities in life, as well as their health and access to quality healthcare services. Many of the participants, especially recent immigrants, who arrived healthy and did not have any concerning symptoms, indicated that such priorities as overcoming the challenges of successful socioeconomic integration for themselves and their families, and often putting the health care and other needs of their families before themselves, tended to overshadow the issue of prevention of potential female cancers.
Through situating the experiences of South Asian women, who participated in the current study, within the antiracist literature and critique of the Canadian immigration policies, multiculturalist discourses and neoliberal ideologies, it became apparent that the historical as well as current policies, institutionalized practices and structural inequities in Canada interact with each other to marginalize these women in both discursive and material ways to shape their health and access to health care including cancer screening services. Within the environment of neoliberal healthcare restructuring, patients and their families are expected to be self-reliant and to assume more responsibilities for health. In the case of female cancer screening, South Asian women are expected to be self-educated through reading brochures in Punjabi or through attending community workshops, and to be self-motivated to ask their physicians for a Pap smear and mammography. But many South Asian women in the current study, especially elderly women expected or demanded that their doctors should inform or educate them on health issues and take responsibility to do whatever is necessary for prevention and treatment of illnesses.

South Asian women, who may be unable to comply with the indiscriminate and standardized neoliberal message of ‘self-care’ due to structural and systemic barriers, are viewed and relegated as the ‘other.’ Furthermore, such women are left on their own and forced to depend on their sponsors or family members, and to accumulate social capital within their ethnic community because there are very little state funded social or community services available for them. In the arena of health care, these women are most often viewed as ‘burden,’ or their ‘otherness’ is attempted to be managed through providing culturally sensitive care. Women’s perspectives and experiences in the current study reflected the need to conceptualize healthcare access in light of the broader social, economic, historical and political contexts of their lives rather than only in terms of cultural beliefs, practices and health behaviours. I argue, the focus on uncritical notion of culture and cultural barriers tends to provide only a partial picture of women’s access to cancer screening and other health services, and ignores the access barriers rooted within women’s immigration, settlement and integration processes. I further argue, health research that tries to measure the level of South Asian women’s acculturation, or attempts to understand simply the cultural barriers to cancer screening, as well as health promotion strategies that aim to educate them on cancer screening through health literacy programs, and clinical practices that try to ensure equitable care simply through providing culturally sensitive care – all fail to fathom the struggles of racialized new and professional immigrant women, and the
challenges of elderly and uneducated women within their own communities and as well within Canadian institutions including health care. I also argue that all these processes reinforce South Asian immigrant women’s historical as well as current racialization, marginalization and construction as the ‘other,’ and negatively impact their health and access to health care in general and cancer screening in particular.

Nevertheless, physician practices related to women’s cancer screening need to be viewed as more than individual actions, and the relations between practitioners and patients need to be understood within the broader structures and power relations as well. The ideological, socio-political and fiscal atmosphere, wherein physicians are pressured to treat maximum number of people within the least possible time using fewest resources, is not conducive to comprehensive care which is responsive to the issues of gender discrimination, racialization and socioeconomic marginalization of South Asian and other ethnic minority immigrant women. Immigrant and ethnic minority health professionals experience significant discrimination and challenges to be accredited or accepted into the Canadian healthcare system. Those who manage to be integrated within the system, also assimilate and work under the same neoliberal atmosphere of cost containment and ideologies of individualism and self care. Moreover, through the discourses of multiculturalism and culturally sensitive care, immigrant or ethnic minority health care and other service providers are essentialized and ‘othered’ as the cultural ‘experts,’ only fit to serve the minority people, or the multicultural ‘others.’

Yet, attempts to homogenize South Asian women as the ‘other’ – as victims of structural forces and institutionalized practices – tend to deny them any agency and ability to make any conscious choices about their health or use of health services. In fact, women’s multiple intersecting positions within the interlocking systems of privilege and power differently shape their ability to enact agency and resist their positioning as the ‘other.’ Participants in this study, depending on their varied age, interests, educational and socioeconomic opportunities, were found to be practicing different health enriching activities and they had differential ability and agency to exercise power and choices, to manipulate resources and extract necessary information and support, to demand better care from their doctors and to change their family physicians when necessary. South Asian women’s health and well-being, their ability to take health enhancing actions and to access health care were facilitated and/or constrained by the intersecting effects of
multiple factors such as age and generation, education and language skills, immigration and integration status, socioeconomic conditions in both home and host countries, rural/urban background in home countries, experience of living abroad before migration to Canada, and their involvement and connections in the community – all of which are connected to gender ideologies, historical as well as current day discrimination, broader socioeconomic and political structures and policies.

My research attempted to find out the ways the socioeconomic locations and contextual features of South Asian immigrant women’s everyday lives limit their access to cancer preventive resources and care. It became apparent that the dynamics of race, class and immigration status intersect with gender in diverse and complex manners in the material and everyday lives of South Asian women to put them into racialized, marginalized and disadvantaged situations as the ‘other’ from where it becomes especially challenging to access health care and preventive cancer screening services in particular. Precisely, considering all the main findings it may be concluded that South Asian immigrant women’s health and access to health care including cancer screening in this study were shaped by their varied personal life circumstances, and by the intersecting socioeconomic and settlement conditions that are determined by broader policies and structural factors within Canadian society including the healthcare system. Based on my analysis of the research data, I came up with the theoretical map or diagram (Figure 7.2) to show how South Asian immigrant women’s access to and experiences with cancer screening in the current study were shaped by the complex intersections of factors that mainly reflected the interplay between physicians and women determined by their personal, social and structural circumstances. And the conclusions of the study as well as the diagram are as grounded in the data, or women’s narratives, as they are influenced by my own reading and interpretation of the data in light of the antiracist theories and literature pertinent to the historical and current positioning of South Asian women as the ‘other,’ which I believe, is shaped by the interlocking racialized and gendered immigration and multicultural policies and neoliberal ideologies in Canada.
Figure 7.2: Women’s Access to and Experiences with Cancer Screening: Intersections of Factors in Personal, Socioeconomic and Structural Contexts of Women’s Lives.
The South Asian women in the circular diagram are located at the center, interacting with their primary care providers or physicians at an individual level. The innermost circle from the center alludes to women’s demographic qualities and personal experiences, health beliefs, understandings and knowledge of cancer screening. The two outer circles or layers reflect the intersecting social and structural contexts of their lives – the larger socioeconomic, political, cultural, material, institutional and discursive issues that shape women’s migration, resettlement, integration and health experiences in Canada. The second circle in the middle includes such issues as presence or absence of extended family support, gender division of labour, poverty/financial insecurities in gendered and racially segregated labour market, systemic and structural barriers to health care, access to social services and community support organizations – all of which interact with each other to shape women’s individual experiences with the Canadian educational institutes, immigrant, community and social services agencies, labour market and healthcare system. The outermost circle represents the interlocking broader power structures – including the state policies and discourses of immigration, multiculturalism, neoliberalism and healthcare restructuring, racializing processes and the ideologies of race, class and gender discrimination – the issues that organize and influence the factors in the middle layer, and eventually impact the everyday life, personal health and healthcare experiences of South Asian immigrant women as the ‘other’ in Canada. Women’s varied life circumstances and experiences of health and health care including cancer screening are shaped by the varied levels of interactions among these personal, social and structural dynamics of their lives.

Most women in the study had a family physician that represented immigrant or minority ethnic communities. These physicians often encounter racialization and marginalization within the white centered healthcare system in Canada, for example, through lack of recognition of their foreign degrees and professional experiences. And these ethnic minority or foreign trained doctors, once integrated within the Canadian system, along with any other physicians irrespective of race, ethnicity or gender, operate under the neoliberal regime of healthcare restructuring characterized by increased demand for efficiency with minimum resource, time and support. Thus, healthcare professionals’ individual clinical practices and their interactions with the women also seem to be shaped by the larger social and structural issues and policies located within the broader circles outside the small circle of their personal life contexts.
Study Limitations and Directions for Future Research

Before highlighting some of the implications of the current study, I acknowledge some of the limitations and challenges of my work which might be addressed in future research on similar topics. Although the small sample was quite diverse in terms of the participants’ age, educational and income status, English language skills and length of residency in Canada, women from Punjab, India were overrepresented in the sample. It was not possible to include in the study women of South Asian origin from all the different source countries in Canada. All the women also had a heterosexual background. The current study tried to examine the common problems faced by South Asian women in accessing both cervical and breast cancer screening including CBE and BSE. However, my conversation with the women concentrated around the issue of their use or lack of use of Pap smear and mammogram and there was a lack of detailed data about clinical and breast self-examination among the women. Moreover, the research was not able to explore or expose the regularity of the use of these services among the women, and rather shed light on the initiation process and the quality of the service received by the women. Neither did it include or represent the healthcare providers’ perspectives on the issue and rather remained limited to the women’s viewpoints.

Looking at both Pap smear and mammogram usage along with CBE and BSE at the same time posed certain challenges, such as increased complexity in analyses and comparisons of data especially in terms of numbers, particularly given the small number of sample and limited data on women’s clinical and breast self exam practices. It was found that some of the women who were using both Pap smear and mammogram were not doing either clinical or breast self exams while very few of the women who never used Pap smear or mammogram occasionally checked their breasts for detecting palpable lumps. Future research may investigate and compare the complex relationships among the use or lack of use of all these female cancer screening practices at a deeper level with larger samples of women representing more diversity.

I was not able to involve the participants in the analysis of data, or to invite any feedback from the participants mainly due to my time constraints and lack of experience, and partially due to lack of time and interest on part of the participants. None of the previous work in the area of South Asian women’s cancer screening has used a participatory or collaborative research
method; therefore there is a particular need for such research. While I was solely in charge of the whole research from designing to analyzing and writing the report, future work could collaborate with research participants or other stakeholders such as healthcare providers including physicians, nurses and community health workers. Furthermore, it has been pointed out in the BC Provincial Health Officer’s Annual Report (2003) that the ongoing scientific debate about the relative merits of mammography screening and the resulting controversies and confusions for both the medical community and women in general could be partially accountable for the lower than desirable participation rate of breast screening among Canadian women. No research so far has explored this issue, particularly among South Asian women. This might be a potential topic for future research, especially appropriate for collaboration among different stakeholders namely the healthcare professionals, community social workers and South Asian women in Canada. Lastly, the theoretical map presented in figure 7.2 was designed through an inductive process and therefore could be verified or tested for its validity through large scale study with South Asian or other ethnic minority immigrant and racialized women.

Implications and Recommendations

As a feminist researcher I started this research from a non-positivist perspective, not to prove any specific hypothesis, but to bridge the data gap with alternative and new knowledge about South Asian immigrant women’s cancer screening. My own location as a South Asian immigrant woman and a feminist scholar has immensely influenced the knowledge produced through this research. Instead of claiming this knowledge and research findings to be universal, complete and true representation of the experiences of all South Asian immigrant women in Canada, I rather acknowledge that the research product is incomplete, partial and located within the relationships established between the participants and me, and influenced by my insider/outsider boundaries during the research process. I have only constructed and presented a partial truth or one of many possible truths about South Asian immigrant women’s cancer screening in the greater Vancouver in Canada. Moreover, findings of any qualitative research have limited scope for generalization because the goal of such research is rather to provide context specific detailed information about human experiences and phenomena of a relatively small sample. Although the current research findings were drawn from a small theoretical sample of South Asian women of diverse socioeconomic and demographic backgrounds, the conclusions
or arguments, based on the transformation of the interview data into meaningful explanations or interpretations about the women’s experiences, have been constructed through following an appropriate methodology or coherent set of logical processes. The current research findings also showed congruencies with many statistical and large scale empirical findings on ethnic minority immigrant women and their health as discussed in the earlier chapters. Therefore, there are certain significance, and important methodological, theoretical as well as practical implications of the current research findings for future research, clinical practices and health care and other related policies.

**Theoretical Implications**

One of the theoretical objectives of the study was to challenge the cultural essentialism and poor theorization of culture noted to be prominent in the literature on South Asian women’s access to cancer preventive services. Such problematic conceptualization of culture fails to grasp culture as complex power relation grounded in diverse social, economic, historical and political contexts (Krane 2001; Browne and Varcoe 2006). As already pointed out, through an overemphasis on South Asian immigrant women’s cultural beliefs, knowledge and understanding about reproductive cancer screening and a lack of focus on these women’s challenges of migration, relocation and racialization that shape their access to health care, the existing literature have constructed them as the cultural ‘other.’ The current study’s emphasis on the challenges and stress of migration and settlement in a new country, systemic racism and poverty, institutional, structural and socioeconomic barriers to accessing healthcare services faced by South Asian immigrant women helped to avoid inappropriate essentializing about these women’s culture and at the same time, gain better understanding of their diversity, subjectivity and agency.

Women’s narratives in the current study reflected that there was no homogenous cultural health beliefs among the South Asian women that determined all these women’s understandings, attitudes and practices around the issue of cancer screening; rather a variety of personal beliefs and perspectives were observed among the women about prevention of female cancer, and the perceived importance of physician recommendation seemed to be the most common and significant belief that impacted their use or lack of use of cancer screening. Lack of perceived need of cancer screening among South Asian women is commonly cited in the literature as a
major factor influencing their lack of use of cancer screening; but the current study noted that women did not ignore preventive care due to cultural beliefs rather due to challenges of settlement, gendered family duties and lack of recommendation, encouragement and support from family physicians. Women’s understandings, use or lack of use of cancer screening services were diversely shaped by many intersecting systemic issues and structural processes, such as, women’s differential access to basic literacy/education, health information, employment, social services, social capital (such as friends and connections), and community resources, as well as health care related factors such as, different clinical practices of family physicians, the nature of physicians’ relationship with women and the level of physicians’ involvement in women’s cancer screening. These findings offered a more complex understanding of the issue and challenged the essentialist theoretical assumptions about South Asian culture as homogenous or static, and as the explanation for South Asian women’s health behaviour related to cancer screening.

By bringing to the forefront women’s gendered and racialized processes of migration, settlement and integration in Canada, the study aimed to understand how these processes impact South Asian immigrant women’s access to quality health care including cancer screening. Findings of the study provided support for Vissandjee, Thurston, Apale and Nahar’s (2007) theorization about women’s migration experiences as a significant health determinant that tends to shape the effects of other generally acknowledged social determinants of women’s health. The current study’s focus on women’s migration experiences showed that the challenges South Asian immigrant women faced in Canada not only impacted their overall health but also shaped their access to overall health care as well as cancer screening. As the current data showed that South Asian women encountered more than cultural and language barriers in accessing cancer screening services, it also signified the importance of theorizing and understanding these women’s access to cancer screening beyond their personal understandings, attitudes, cultural beliefs and practices around health, cancer and cancer screening. The current study’s unique approach to understanding the broader contexts of immigrant women’s everyday lives and their general experiences with primary care in Canada uncovered and confirmed the structural and systemic barriers that particularly impacted women’s participation in cancer screening. It also theoretically implied that women’s personal health issues cannot be separated or understood in isolation from the larger social, political, historical, material and discursive contexts of their
lives. My research thus signified the importance of viewing or examining ethnic minority immigrant and racialized women’s access to cancer screening and other health services with the lens of intersectionality within the socioeconomic, political and historical processes that create structural and systemic barriers to resources and services.

All these implications indicate the need to reject the culturalist construction of knowledge about certain ethnic communities whereby culture is essentialized and overemphasized and the structural and systemic barriers to health care are ignored. These further demonstrate the limitations of the concept of culturally sensitive care – a neoliberal approach to managing the health needs of multicultural populations – in effectively addressing the health inequities and inequitable access to health care experienced by South Asian and other marginalized women in Canada. Moreover, the neoliberal concepts of ‘self-care,’ ‘individual responsibility’ and ‘choice’ seem to have very limited significance for South Asian women with limited literacy and access to organized or formal support for their successful socioeconomic integration. Overgeneralizations and stereotypical assumptions about South Asian immigrant women’s cultural beliefs and health needs must be avoided. South Asians, like any other community, are diverse despite their commonalities of ethnic background. The general expectations and assumptions about the availability of social support or social capital in South Asian communities are grounded in the conceptualization of community as a homogenous category. South Asian community needs to be conceptualized as a socially constructed and political category in the larger contexts of the historical and current processes of their racialization as well as their antiracist struggle/solidarity, as suggested by antiracist theorists (such as, Bannerji 2000; Ponic 2007). The current project showed the significance of critical cultural perspectives, informed by antiracist and intersectionality theories, to view culture and community as inseparable from other social locations of race, gender and class; to consider historical, structural, political-economic and ideological forces that create power imbalances and socioeconomic inequities leading to health inequities among populations; and as well to address the health inequities. The diagram, informed by such critical perspectives, (Figure 7.2) that showed South Asian women’s access to cancer screening as shaped by the complex intersections among various factors in women’s personal, social and structural life contexts may have broader implications in understanding the reproductive cancer and other health issues of South Asian as well as other racialized and marginalized women in general in Canada.
Methodological Implications

While quantitative studies have overlooked the voices and lived experiences of South Asian immigrant women, a good number of studies have used qualitative methodologies to incorporate and represent these women’s personal perspectives and voices regarding their cultural health beliefs and understandings about reproductive cancer and importance of cancer screening. But their essentialist conceptualization of culture, however, has resulted in objectifying these women as the ‘other.’ Women’s narratives and accounts of their everyday lives are the cornerstone of feminist qualitative methodologies; and women’s personal accounts in this study provided an entry point for exploring how their historical and social locations of race, class, gender and immigration status intersected to shape their health and access to health care. Through the use of qualitative methodologies the current study not only emphasized and illustrated South Asian women’s health experiences in the contexts of their everyday lives shaped by their racialized and gendered processes of immigration, relocation and settlement, but also resisted their representation as the cultural ‘other’ implicit in most of the literature on South Asian women’s cancer screening.

The use of intersectionality in interpreting the research data also offered methodological uniqueness to the current study. The study’s focus on an intersectional analysis of South Asian women’s experiences as shaped by both advantages and disadvantages of immigration and their varied interactions with women’s race, gender, socioeconomic class, religion, age and other social locations helped to acknowledge and portray the women as active agents rather than passive ‘victims’ of structural forces as well as culture. The lens of intersectionality enabled me to view the diverse experiences of individual South Asian women as determined by their dynamic social locations of race, class, age, immigration status and so on, and at the same time, to explore how individual experiences are shaped by their historical and structural construction as the ‘other’ through the discourses and policies of immigration, multiculturalism and neoliberal individualism.

Although large-scale quantitative research data are helpful in getting attention and response from government officials and policy makers, many of the complexities and nuances of personal experiences and social relationships are lost in quantitative data. Hence, Weber and
Parra Medina (2003) note that there is a rising awareness within the traditional health inequities research about the need for new approaches, such as intersectionality, to address the problem of ongoing health inequities. Intersectionality helps to understand the complex social relationships of power underlying health, to apprehend the ways that these relationships of power are created and maintained, and thus to understand the ways that they may be modified to reduce disparities in health (Mullings and Schulz 2006). Thus the methodological along with the theoretical implications of the research bear particular significance for policy and practice as well, especially in enhancing South Asian and other racialized women’s equitable access to healthcare services including cancer screening.

**Practical Implications and Recommendations**

As Reinharz pointed out, “much feminist research is connected to social change and social policy questions” (1992, 251) – either through making intellectual contributions or policy recommendations for social, structural and material changes, or through challenging oppressive ideologies and discourses, and through creating transformation and intervention into actual clinical and healthcare practices. The current project shifted the gaze from ‘South Asian culture’ to the intersections of the broader structures and interlocking systems that produce health inequities and inequitable access to health care. I used antiracist and intersectionality frameworks as well as a social justice approach to construct new knowledge that can be used to change policy and health practices to improve South Asian and other ethnic minority immigrant women’s health and access to health care, especially cancer screening services. The intersectional analysis of the current data implies that strategies to promote health equity must consider the larger structural, social and political processes that produce health inequities. Screening can prevent cancers only to the extent that early treatment and cure can be provided through early detection. Focus on women’s health behaviour and cultural health practices as barriers to getting cancer screening done draws attention away from the processes that produce ill health including cancers. General improvement of the racialized immigrants’ socioeconomic status or the social determinants of health will improve the health status and access to health care of immigrant and other marginalized women. The critical and complex analysis of the current study should be useful for researchers, policy makers and health service providers in developing future research, policies and healthcare practices more critically in order to improve the quality and accessibility
of cancer screening and other healthcare services in general for South Asian and other racialized or marginalized women. On the basis of what I learned from the experiences and perspectives of the women, I finally suggest some recommendations to transform the intertwined areas of research, policies and practices that could make cancer screening as well as the general healthcare services more equitable and accessible for people in Canada irrespective of their gender, race/ethnicity, class, immigration status and English language skills.

**Re/Framing Research**

Feminist and intersectionality research is concerned with not just creating grand theories but promoting actions to change the status quo, or transform the social relations of power in order to achieve equity and social justice. Structural, social, ideological and material changes often require shifts in how we do research or frame the research problem. South Asian and other racialized women’s health research needs to avoid the processes of ‘othering’ through categorizing people according to a single cultural identity or community. The conflation and confounding of ethnicity with culture, both of which are fluid and shifting categories, should also be shunned. Racialized and marginalized women’s health experiences should rather be examined and understood within the broader contexts and interlocking systems of oppressions.

The simplistic, reductionist and culturalist approach to producing knowledge about racialized minority men and women needs to be challenged and replaced by more critical and complex knowledge of their health. This will involve shifting dominant ideologies that inform power relations and hierarchies and impact health. Interdisciplinary, community-based and participatory research involving qualitative, quantitative and mixed or integrated methods informed by intersectionality framework and grounded on values of equity and social justice can produce alternative knowledge and contribute to the structural changes required to ensure equitable healthcare for all women and men. On the one hand, we need to challenge the traditional biomedical focus on genetic, behavioural or lifestyle aspects of individual’s health and on the other hand, biomedical research needs to be informed by critical and social justice approach and intersectionality analyses. The neoliberal notions of ‘patient empowerment’ and ‘individual responsibility and self-care’ should also be further contested and examined within the contexts of structural inequities experienced by racialized and marginalized men and women. A more critical understanding of the intersecting social determinants of health and the broader
processes, policies and discourses that intersect to generate and maintain social inequities is also needed. Such knowledge, understandings and intersectional analyses of structural inequities should then be integrated into relevant policy making.

**Developing Economic and Social Policies that Support Health**

Equitable and just health care means removing the structural and systemic barriers to access to the basic necessities of life including health care, rather than the problematic neoliberal ideology and policy of ‘treating everyone the same’ despite the immense socioeconomic inequalities among populations. Many of the determinants of health inequalities lie outside the healthcare system and reducing inequities between income groups is an important goal for government policy through which health inequalities between different groups can be eradicated (Raphael 2004, 4). Thus health promotion activities should target reducing social inequalities in health. The erosion of Canada’s welfare system and rise of the neoliberal economy approach that emphasizes economic globalization and the role of markets in organizing and allocating resources are the root cause of increased income and wealth inequalities in the country (Anderson 2000; Ponic 2007; Raphael 2004). To engrain the values of fairness and justice into society, income opportunities, wealth and health resources need to be organized and distributed equitably, so that access to those remains open to everybody. General health inequities can be addressed through reduction of poverty and underemployment among immigrant populations, elimination of gender discrimination and racialized practices such as, lack of validation of education/training and professional skills of South Asian immigrants, ghettoization of immigrant women into low-paying or low status jobs and into poor ethnic neighbourhoods. Improving access to better quality housing, social services and community support, transportation and childcare support will also enhance South Asian and other immigrant women’s health and access to cancer screening as well as other healthcare services.

The overall lower socioeconomic status of South Asian immigrant women and other ethnic minority women, that is, their status as the ‘other,’ is created and maintained by the structural barriers set by immigration policies in tandem with other discriminatory education and labour market systems in Canada, and also by the gendered ideologies and practices and their complex interactions with immigration/settlement status and other socioeconomic factors. Sponsored immigrant women do not enjoy the entitlements to state funded social and settlement
services offered to independent class immigrants or even sponsored male immigrants (Habib 2003, Zaman 2006). These women face gendered and multiple intersecting barriers to accessing information and other resources and services. Their improved and easier access to social entitlements and community services should be ensured through removing bureaucratic obstacles and ensuring increased funding for such services. To uphold the basic human rights of all immigrants regardless of their entry level status Canada should take more responsibility for the establishment and integration of its immigrants in order to reduce socioeconomic inequities among and between residents and citizens. Immigrant women should be provided with better access to social services, state-funded language and job training courses, and other services needed for better integration into Canadian society in order to remove the multiple intersecting barriers to their participation in Canadian society ensure their equality with immigrant men and native-born women.

Lack of accreditation of academic and professional qualifications, and un/der-employment leading to lack of social and financial autonomy for skilled and educated immigrant women is a major problem that imparts negative impacts on their health and access to health care. Racialized immigrant people have long been demanding for a standardized method to easily and rapidly measure and convert foreign credentials into Canadian units so that both employers and recent immigrants can hire or look for appropriate jobs according to their credentials. This must be a policy priority in Canada. Low literacy rates and limited English language skills among many recent immigrant populations including South Asian elderly women tend to have personal health impacts as well as economic and social cost, especially for immigrant families. Therefore, developing and implementing more effective, inclusive and accessible adult literacy and ESL training programs for disadvantaged women are important to improving socioeconomic and health equities among populations.

Policies and interventions targeting increased health literacy through publishing leaflets or pamphlets in Punjabi) miss the women without any formal schooling or basic literacy even in Punjabi. Therefore, these women need to be educated on such health issues through different means (public media – radio, TV) rather than through brochures. Health awareness may be raised through community outreach programs, consciousness raising workshops and campaigns in South Asian languages at health centers and community functions and to women’s groups. But
the health literacy campaigns also make limited appeal to the racialized women who are overwhelmed by the demands and stress of successful settlement and socioeconomic integration in a new country with limited support from the state. Elderly South Asian women need to be literate, educated and empowered so that they gain the agency and ability to freely explain their health problems and ask questions to their physicians. These women cannot be empowered simply by being showered with health information, or without improving their education and literacy skills and sources of secured income. Improved access to basic literacy/education, English language training, employment with better payment and more benefits, and appropriate health information will likely result in women’s empowerment as well as long-term positive health outcomes and better access to preventive care such as, cancer screening.

Policy makers must be cognizant of the various ways immigration/settlement, socioeconomic and structural factors influence health and health care utilization among immigrant and ethnic minority people. South Asian and other immigrant men and women have to be represented, recognized and treated by policy makers and service providers as equally entitled to all kinds of services and programs including quality health care, and not as candidates for simply culturally sensitive care. They should also be involved as participants in making decisions and policies. Canada has historically depended on immigrant populations and continues to bring in new immigrants for economic development and nation building, but the ‘othering’ of ethnic minority immigrants continues. Unfortunately, immigration, settlement and community services and programs seriously suffer from funding cutbacks by federal and provincial governments and shrink the limited upgrading and empowering opportunities for immigrants. But without ensuring adequate funding for such programs and without improving South Asian and other ethnic minority immigrant women’s access to such programs their status as the ‘other’ cannot be countered.

**Improving Services and Clinical Practices**

Women’s access to cancer screening services in this study was related to their access to general health care and especially to the quality of primary care that they received. Therefore, improving the general access to primary care, especially to family physicians will by extension improve women’s access to cancer screening services. Having a family physician – male or female, South Asian or non-South Asian – was not enough, given the tremendous importance the participants
put on receiving physician recommendations and reminders for cancer screening. We need not just more female and South Asian physicians and nurses, but also improved family practice set-up and a more patient-centered and prevention-focused primary care. As the participants in this study unanimously insisted, family physicians should educate or inform women, especially recent and elderly immigrants, about the importance of reproductive cancer screening and initiate the processes of both Pap smear and mammogram. Family physicians can also be important source of support for new immigrants who have limited knowledge and familiarity about novel health care and other systems in Canada.

Physicians should recommend screening to all eligible patients, especially socioeconomically disadvantaged women, who are less likely to be screened than other women. This may entail providing necessary support and training for healthcare providers, especially family physicians. In Australia, financial incentives have been introduced to encourage general practitioners to increase women’s participation in cervical screening. These include payments for screening un-screened or under-screened women in the target populations and incentives for practices to reach the specified target screening rate. Although there is limited research on how such incentive payments change the behaviour of providers or patients (Fiebig et al. 2009) such incentives for general practitioners or family physicians may help increase uptake for South Asian and other women who have low participation in reproductive cancer screening.

At other fronts, community based collaborative support programs for women may help address multiple intersecting barriers women face to acquire knowledge in South Asian languages and help in building awareness and positive attitude among women and their families towards having cancer screening. Such programs could build capacity in women to overcome barriers to effective primary care, and promote cancer screening emphasizing its value and safety. Additionally, more interpreters and better interpreter services are needed for women with limited English language ability. Elderly women without much literacy or education are likely to learn about health issues and services in a story-telling manner from personal interactions with friends, neighbours and community members rather than from brochures or print materials. Most women also prefer female doctors or nurses whom they can feel comfortable with, and who would take the time to listen to or explain not just cancer screening but other health issues and procedures. Nurses who work in community health settings directly with South Asian women could inform
and educate them about cancer screening and its importance. Women may feel more comfortable with community nurses who can speak South Asian language/s and build long term positive, trustworthy and less hierarchical patient-provider relationships. Lastly, in order to ensure good quality services, health care and other service providers need to be sensitive not only to the cultural issues but to the diverse age/generations, educational backgrounds of various South Asian women and to the varied levels of their immigration, empowerment and settlement or socioeconomic integration in Canada.

**Conclusion**

This study set out to explore in a feminist qualitative research how the South Asian women participants engaged in breast and cervical cancer screening processes in greater Vancouver, Canada. Women’s narratives showed that their varied levels of participation in breast and/or cervical cancer screening were shaped by several interconnected influences that mainly reflected the complex interplay between physicians and women determined by the personal, social and structural circumstances of both the women and their physicians. Although some of the women expressed some personal health beliefs about prevention of cancer that intersected with various other entangled issues to hinder their participation in cancer screening, women’s narratives in general did not reflect any unified South Asian cultural health beliefs that seemed to determine all these women’s participation in cancer screening. One of the most important influences on their participation in cancer screening or lack thereof, however, appeared to be the perceived importance of physician recommendation. Ironically, a lack of a standard practice among family physicians in terms of recommending and educating women about the importance of preventive cancer care seemed to be an important barrier to South Asian women’s access to cancer screening. Thus data of this study showed that South Asian women encountered more than cultural and language barriers in accessing cancer screening services.

My research attempted to situate South Asian women’s participation in cancer screening within the broader contexts of their migration and settlement experiences in order explore to what extent these women under-utilized preventive cancer screening services due to systemic and structural barriers in and outside of the healthcare system, rather than due to cultural health beliefs and practices related to cancer screening. In general, research data showed that the immigration factor intensified the intersecting forms of inequities and the social determinants of
health in Canada, such as gender, class, poverty, racialization and discrimination, and adversely affected women’s health and access to healthcare services, cancer screening being one of them. Financial instability, under/employment, lack of English language skills and familiarity with the healthcare system, inadequate access to settlement and social services and other resources were some of the common barriers to the socioeconomic integration and equitable access to healthcare services for South Asian immigrant women, especially the newly arrived. The gendered roles and responsibilities of homemaking and childrearing, most often in absence of extended family support, also amplified the challenges of migration and settlement and impacted women’s health as well as access to health care. These structural barriers directly or indirectly influenced many South Asian women’s access to and participation in female cancer screening in Canada. Thus South Asian immigrant women’s common challenges of gendered and racialized processes of migration, settlement and socioeconomic integration, along with the structural barriers within the healthcare system shaped their marginalized and vulnerable positionalities, which in effect impacted their access to cancer screening services.

This study also aimed to know how women’s migration and settlement experiences in Canada are shaped by the racialized and gendered immigration and integration policies, multicultural discourses and neoliberal ideologies and practices, and how these broader forces influence women’s access to cancer screening and other healthcare services. An intersectional examination of the broader discourses, policies and processes that create and sustain the social inequities for immigrants and govern the health care and clinical practices of healthcare providers revealed that race, class and immigration status intersect with gender in diverse and complex manners in the material and everyday lives of South Asian women to situate them into racialized and disadvantaged situations as the ‘other.’ Accessing health care, especially preventive cancer screening services from such positions seems to pose significant challenges for many South Asian immigrant women, especially recent immigrants and elderly women with limited literacy and English language skills. On the one hand, through the Canadian immigration, settlement and integration policies South Asian women are constructed as the multicultural ‘other’ both at the lower echelon of racially and sexually segregated labour market and at the edge of Canada’s white-centred national imagery. On the other hand, the neoliberal notion of ‘treating everyone the same’ overlooks the struggles of racialized new immigrant women, and the special challenges and needs of elderly women without literacy, and thus reify their
marginalization and status as the ‘other.’ The policy and systemic barriers that hinder racialized new immigrants’ economic, political and social integration in Canada, and create these women’s position as the ‘other,’ in the long run negatively impact their physical and mental health and access to health care including cancer screening. Thus, the intersectional analysis in this research indicates that the problem of South Asian women’s inadequate access to cancer screening cannot be separated from the larger social, political, historical, material and discursive contexts of their lives.

To conclude, improving access to healthcare services is complicated and involves more than ensuring universal or ‘free’ financial access and providing services in a culturally sensitive manner. South Asian women’s access to cancer screening and other healthcare services need to be understood outside the limiting ideas of providing services according to these women’s health beliefs, behaviours and cultural practices, and instead, within the broader contexts of their everyday lives as shaped by intersecting relations of power (race, gender, class, age and immigration status among others). Cultural sensitivity approach to health service delivery alone cannot ensure better access for racialized women who face structural and systemic barriers to healthcare services and socioeconomic integration in Canada; broader policy changes are required to address social inequities. In the current study, South Asian immigrant women’s varied experiences of migration, settlement, integration and access to health care indicated that these women are a diverse group facing various intersecting barriers and challenges both inside and outside the Canadian healthcare system. Therefore, any monolithic attempt to improve ethnic minority women’s health status or access to services through trying to understand their cultural practices and behavioural patterns will likely be unsuccessful. Multi-pronged and multi-layered strategies need to focus on broader policies and forces beyond cultural issues, beyond the indiscriminate neoliberal approach to self-reliance/-care, beyond improving health literacy through brochures. The strategies should rather be able to address the diverse needs and health practices of South Asian immigrant women. Structural changes need to happen at different levels and in different organizations and institutional practices.
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APPENDICES

Appendix A: Letter of Consent & Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

Consent Form for Interview: South Asian Women and Cancer Screening

Title of the Research Study: South Asian Immigrant Women’s Experiences with and Access to Breast and Cervical Cancer Screening Services in Canada

Principal Investigators: Dr. Sunera Thobani, Associate Professor, Center for Women’s & Gender Studies, University of British Columbia, Vancouver, Canada; and Dr. Colleen Varcoe, Associate Professor, School of Nursing, University of British Columbia, Vancouver, Canada.

Co-Investigator: Sanzida Z Habib, Doctoral Candidate, Centre for Women’s and Gender Studies, University of British Columbia, Vancouver, Canada (who will undertake this fieldwork).

Purpose: This study aims to understand South Asian immigrant women’s use of breast and cervical cancer screening services as shaped by their everyday life experiences of immigration and resettlement and their overall experience with the Canadian health care system. This research is being undertaken as part of Sanzida Habib’s doctoral dissertation research at the Centre for Women’s and Gender Studies at the University of British Columbia, Vancouver, Canada.

Study Procedures: You are invited to participate in an interview that will last about 2 hours. You will be asked questions about your experiences of immigration and integration and adaptation in Canada, your experiences with the Canadian health care system, you breast and cervical health practices. The interview will be tape recorded with your permission. If you prefer not to be taped, I will ask your permission to take notes as you talk.

You may refuse to participate or to answer any specific questions during the interview. You are

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also free to withdraw from participating at any time with no consequences.

If you are willing to participate, written approval or consent of your participation is necessary.

**Confidentiality:** The researcher will hold all the information collected in strict confidence. Only the researcher and the supervisory committee for the doctoral thesis will have access to any original transcripts. You can use a made-up name (pseudonym) for the study. Every attempt will be made to exclude details that identify you and only the researcher will know who you are. The recording and the transcripts will be done by the researcher with identification code numbers or pseudonyms. Any report or publication, resulting from the data or information you provide, will not contain any identifying information. If you want confidentiality, every effort will be made to ensure and maintain confidentiality throughout the project and in any publication. All records will be kept in a locked cabinet at the Center for Women’s and Gender Studies at UBC. The information will be kept for 5 years and after that it will be destroyed.

**Contact for information about this study:**
If at any time you have any question or desire further information with respect to this study, please feel free to contact Dr. Sunera Thobani at xxx-xxx-xxxx (email: xxxxx@email.com) or Sanzida Habib at xxx-xxx-xxxx (email: xxxxx@email.com).

**Contact for concerns about the rights of research subjects:**
If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, contact the Research Subject Information Line in the University of British Columbia Office of Research Services at 604-822-8598.

**Consent:**
I have read the above information and have had an opportunity to ask questions about the research project and about my participation. I freely consent to participate in the study, and acknowledge receipt of a copy of the consent form.

_________________________  __________________________
Participant Signature Date

_________________________
Participant Name (Please Print)
Advertisement Message

South Asian Women and Cancer Screening

Do you consider yourself a South Asian immigrant woman?

I would like to talk to you about cancer screening. I am a South Asian immigrant woman and a PhD student at the Centre for Women’s and Gender Studies at the University of British Columbia in Vancouver, Canada. The topic of my PhD research is “South Asian Immigrant Women’s Experiences with and Access to Breast and Cervical Cancer Screening Services in Canada.”

All conversations are completely confidential and your identity will be protected at all stages. If you participate in an interview (approximately 2 hrs) you will be given a small token payment ($20.00) in appreciation of your assistance and the amount of time dedicated for the study. You will also be provided with travel expenses and/or childcare costs, if need be, in order to take part in the study.

If you are interested in participating or would like more information about the research please contact me at: xxx-xxx-xxxx, or email me at xxxxx@email.com

The interview/conversation can be done in English/Bangla/Hindi/Urdu according to your preference. The research project is being supervised by UBC professors of Women’s Studies and Nursing, and has been granted ethical approval by the Behavioural Research Ethics Board (UBC BREB NUMBER: H08-02121).

Thank you.
Appendix C: Letter to Agency

THE UNIVERSITY OF BRITISH COLUMBIA

Date: September 1, 2008

Letter of Contact to Agencies for Recruitment Help

Dear Madam/Sir,

I am a PhD candidate at the Center for Women’s and Gender Studies at the University of British Columbia. I am writing to request your assistance with recruiting participants for my dissertation research (a requirement of my doctoral degree) on South Asian Women and Cancer Screening. Your organization has been selected because you provide community and family services to South Asian immigrant women.

The title of my PhD research is “South Asian Immigrant Women’s Experiences with and Access to Breast and Cervical Cancer Screening Services in Canada.” The study aims to understand South Asian immigrant women’s use of breast and cervical cancer screening services as shaped by their everyday life experiences of immigration and resettlement and their overall experience with the Canadian health care system. The participants will be asked some broad open-ended questions about their experiences of immigration and adaptation in Canada, experiences with the Canadian health care system, and breast and cervical health preventive practices. Based on the experiences and perspectives of these women some policy recommendations will be generated to make these services more equitable and accessible.

I am particularly asking for your help in making South Asian women aware of the study. I need your permission to post an advertisement asking for participation of interested South Asian women into my study. Attached, please find copies of the advertisement, and the individual consent form that explains the purpose and procedure of the research project. I would request
you to distribute the advertisement via email to members of the South Asian community should you have any listserv of such clients and community members.

You are also requested to provide potential participants with the information or description about the study given in the consent form. Alternatively you can provide me with the contact info (for example, phone number) of the interested women upon receiving her permission or consent.

You or your agency will not be held responsible for the study or any problems, if at all, arising from the study. You’ll be provided with copies of the final dissertation or any publications resulting from the research if you wish or require. Research findings may also be shared through oral presentations in a special session or as part of any relevant program organized by your organization.

If you have any further questions I will be happy to meet and discuss with you the aims and procedures of the research project.

If you are willing to assist with the research project, a written approval (for example, email reply) of your agency (to use the premises and to access clients of your agency) will be required.

I look forward to your response at your earliest convenience.

Thank you for your time and kind cooperation.

Yours sincerely,

Sanzida Z Habib
PhD Candidate
Center for Women’s and Gender Studies
University of British Columbia
Vancouver
Residence Phone: xxx-xxx-xxxx
e-mail: xxxxx@email.com
Appendix D: Interview Guide & Demographic Data Sheet

South Asian Immigrant Women’s Experiences with and Access to Breast and Cervical Cancer Screening Services in Canada

Interview layout: Guiding or Invitational Questions

[Since the interview is intended to be qualitative and in-depth in nature, the participant will be asked some broad and open-ended questions about her experiences of immigration and adaptation in Canada, experiences with the Canadian health care system, and breast and cervical health preventive practices. The participant will be presented with a preamble and invited to speak freely on the issue. If she does not cover aspects that are salient to the study, some prompts/probes will be used. The researcher will use the following guidelines during interview. The guidelines will be verbally adapted into Bangla, Hindi or Urdu when the participant chooses to speak in any of those languages.]

Preamble: “Thank you for agreeing to participate in this study. As you know we are trying to understand South Asian immigrant women’s everyday life experiences of immigration and resettlement and their experience with the Canadian health care system, especially breast and cervical cancer screening services. So, I’d like to hear from you about your day-to-day experiences as an immigrant woman from South Asia, your experiences with the Canadian health care system in general and breast and cervical cancer screening in particular. This will be more of a conversation or dialogue rather than formal question and answer. You are expected to speak from your personal experiences, and there is no right or wrong answer. I would like to hear whatever you would like or decide to tell me and you’re free to start with whatever you like.”

Immigration and settlement experience:

1. Could you tell me about your immigration experience? Why and how did you migrate to Canada?
2. What was your life like back home? [pre-migration – education/work, family, health, health care…]
3. How do you like your life in Canada – things you like or don’t like, and the challenges you face here…how would you describe your overall experience in Canada? What are the challenges you faced as an immigrant?
4. Could you tell me about your community and your involvement with your own or other communities here in Vancouver?
5. Did any person/organization help you in the settlement process after you first came to Canada? If yes, can you tell me how?
Experiences with and access to the health care system:

1. After moving to Canada, how did you first find out about the Canadian health care system - doctors, nurses, health care services, clinic, hospital …?
2. Where do you usually go to seek treatment or care for any health needs or problems?
3. Tell me a little bit about your doctor…Do you have a family doctor? If no, could you tell me why?
4. Do you consider yourself a healthy woman? Has your health significantly changed since you moved to Canada?
5. What are the problems/challenges you usually face in seeking any health care?
6. What is you most pleasant or unpleasant experience with the Canadian healthcare system?
7. How would you describe your overall experience with the Canadian healthcare system?

Different levels/degrees of cancer preventative practices:

1. Have you ever done a Pap smear test (screening for cervical cancer) and/or Mammogram (Breast X-ray - if you are over 40 or recommended to do one by a health professional) or Clinical Breast Examination (CBA) – in Canada or elsewhere?
   - What is your understanding of these tests or processes?
   - How did you know about the service or tests?
   - When is the last time (approximately) you had a Pap smear? Or a Mammogram/CBA? How regularly do you do it?
   - Could you tell me why/why not? (risk factors, recommendation, diagnosis, fear of screening or cancer, denial, distrust of biomedicine, alternative practices, or any other reasons …)
   - Would you tell me about your experiences with Pap smear test or mammogram/CBA? What is this experience like? (equipment, staff, test-result, support…)

2. Do you engage in any type of breast/cervical cancer/health prevention other than screening? [Such as, any kind of medication (folk/Ayurvedic medicine), or do any other practices (yoga/exercise, diet, Breast Self-Examination) etc to prevent breast/cervical cancers?]

3. What would you recommend be changed about the Canadian health system in general and cancer screening services in particular to make it more accessible to you or to provide better care for you?
**Personal and Demographic information:**

How do you identify yourself? – Canadian/South Asian Canadian/South Asian immigrant/women of color/other …?
Age:
Marital Status:
Country of birth:
Length of stay in Canada/Vancouver:
Religion:
First language:
Other language skills:
Educational qualification/highest level of schooling:
Yearly family income:
Number of people in family:
Dependent child/ren and their age:

Do you own or rent the house you live in (no. of rooms)?
What kind(s) of work do you do? Part time or full time paid/unpaid? Professional, service sector, customer service, managerial, food industry, govt job, or other, volunteer work?
What kind(s) of work does your spouse do?
How would you define your socio-economic class – working/poor/middle/upper middle/upper class?
Do you have any chronic health problem?

Would you like to add or ask anything more?
Would you like to see the transcribed/translated copy of your responses?
Would you like a copy of this research report?
Would you like to give yourself a pseudonym?

Thank you for your time and contribution to the study.
Appendix E: List of Codes

Codes and sub-codes with number of coded segments

Code System [106]

women's agency/empowerment status [45]
immigration/settlement experience and health [8]
  length of stay/settlement status [88]
  age [31]
  category of immigration [27]
  community/organizations [41]
  education and language skills [49]
  experience of living abroad [9]
  family structure and responsibility [14]
  gender [25]
  SES [67]
  level of stress [9]
  nature of job/employment [19]
  support system [37]
  transnational mobility [6]

understanding about mammogram and/or papsmear [23]
  education and language skills [6]
  level of education/role of family doctor [8]
  health beliefs [18]
  previous experience with pap smear and mammogram [4]
  overall health consciousness [23]
  understanding/awareness about cancer [4]

level of use: pap smear [27]
  family history/symptoms [6]
  knowledge/understanding [17]
  previous use [7]
  role of family doctor [32]

level of use: mammogram [21]
  family history [3]
  knowledge/understanding [10]
  previous use/complications [13]
  barrier [23]
  barrier [1]
  role of family doctor [31]

breast self-exam/clinical exam [17]
experience with the screening process [23]
experience/encounter with health care system [43]
  negative experiences [17]
  positive experiences [9]
  language and other barriers [32]
family doctor [37]
  health status/chronic conditions [69]
  nature of relationship/interaction [20]
  gender/age/ethnicity [46]

Sets [0]