A GEOGRAPHY OF HEALTH AND ETHNICITY:
THE HEALTH CONCERNS OF SOUTH ASIAN FIJIAN WOMEN
LIVING IN GREATER VANCOUVER BRITISH COLUMBIA

by

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B.A., University of the South Pacific, 1991
Post-Graduate Diploma, University of the South Pacific, 1992

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF ARTS

in the Department of Geography

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ABSTRACT

This thesis reports the results of a research project designed to investigate the health and health care experiences of South Asian Fijian women currently living in the Greater Vancouver area of British Columbia (B.C.). The health of B.C.'s growing immigrant population was identified as a priority issue in a recent Royal Commission report on health care and costs (1991). In addition, recent directions in health geography which probe the role of space and place in social life provide the opportunity to explore relationships between place and health in the context of the immigration experience. This research is based on data collected through depth interviews conducted in the summer of 1994 with twenty South Asian Fijian women and nine health/community service providers. Health and health care experiences in B.C. are explored in the context of women's everyday lives, as they are contextualized within the immigration experience. Interviews were taped and transcribed verbatim, then analyzed for major themes. It was found that immigrant women face numerous challenges, most of which impact upon their health and well-being. In virtually all cases, women mentioned emotional well-being as a central health concept. Many women also reported the importance of place, of 'feeling at home', as a

primary determinant of their ability to achieve health. Further, individual definitions of health often went beyond illness and disease to include broader conceptions of well-being. Varying levels of success in accessing the health care system were reported and appear to be related to social support networks, opportunities for employment and language ability. These findings have implications for how we conceptualize health and how health care services are delivered to particular groups. In addition, this research contributes to current literature in health geography which seeks to illuminate local contextual factors and subjective experience which mediate between and impact upon wider sets of social relations to create health in place.

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ACKNOWLEDGEMENTS

This thesis represents the joint effort of many individuals, most importantly, twenty-nine women who gave their time freely, and shared the richness of their life experience with me. Sincere thanks are due to all of you. The special efforts of "Vinita" and "Verinder" are deeply appreciated.

I would also like to thank my thesis supervisor, Dr. Susan Elliott, for her endless patience in answering my questions, and whose expertise and guidance were invaluable. Dr. Pamela Moss, my departmental member, and Dr. Peter Stephenson, my outside member, were also endlessly patient and helpful - special thanks to you both for your assistance.

The generous financial support of the British Columbia Health Research Foundation made it possible for me to undertake this research project. I extend my sincere thanks and gratitude to the Foundation for their support during this two year effort.

Thanks are also due to all of those who listened and discussed my work with me, and to the "grad centre" group who made Wednesday evenings in the Spring of '95 something to really look forward to. Last, but not least, I would like to thank Ms. P. Cognac, for her timely suggestions to pause for reflection.

DEDICATION

To Joyti.

CHAPTER ONE: INTRODUCTION

1.1 The Research Problem

There are few studies in the literature which address women's perceptions of their health concerns. Past health research has focused primarily on biomedical models of health (defined simply as the "absence of disease"; Romanucci-Ross and Moerman, 1991), which typically ignores cultural, social and economic determinants of health (Lock and Bibeau, 1993). In addition, much past health research is considered gender-blind, with the primary focus being men and men's diseases (Koblinsky et al, 1993). To address these gaps and to inform health knowledge there is a need to solicit input from all individuals, including women, and particularly immigrant women regarding their health experiences (Walters, 1992). Research which involves women will contribute to individual and community empowerment (Dyck, 1992) and more informed health policy (B.C. Min. Health, 1993a, 1993b, 1993c, 1994).

1.2 Scope and Context of the Thesis

The definition of health has evolved from the "absence of disease" (Kugelman, 1991; Lock and Scheper-Hughes, 1990), to a "state of complete physical, mental and social well-being" (BCRCHCC, 1991: B-4), and is now considered a "resource for everyday life" (Epp, 1986; WHO, 1986).

> Health is the extent to which we can fulfill our needs and goals, and change or cope with our environment...[it] goes beyond physical capacities, to emphasize social and personal resources (Min. Health, 1993a).

Health is a socially constructed concept (Kearns, 1994; Edginton, 1989). Hence, health and health care must be re-examined in light of these evolving definitions of health as well as the changing roles of women.

> Women no longer accept the roles that the traditional health care system once expected them to play... the health care system must change to keep pace with the changing needs of women (BCRCHCC, 1991: A-7).

In addition, the health of B.C.'s growing immigrant population was identified as a priority issue in a recent Royal Commission report of health care and costs (1991). In response to the recommendations of the Royal Commission report, the B.C. government developed a framework for developing a broader definition of health, a shared vision and a common mission for improving the health of, and health care delivery to, all British Columbians (*New Directions*, 1993b). This report identifies target groups which are directly affected by changing definitions of health. Priority action areas have been identified, including the development of specific health policy frameworks to meet the needs of multicultural populations, women and seniors.

The study area for this thesis is particularly significant in light of the identification of women and

multicultural populations for priority action. "Between 1975 and 1990, 1,908,415 people immigrated to Canada. Of this number 279,031 (14.6%) took up residence in British Columbia, the majority of these in the Lower Mainland" (BCRCHCC, 1991: C-358).

> The commitment of the Province to universal health care demands that attention be paid to cultural and linguistic factors. . .however surveys suggest that many people of minority ethnic background are not using existing services because those services are not culturally responsive or accessible to them (BCRCHCC, 1991: C-36).

For example, a study prepared by the Immigrant Services Society of British Columbia (1993) of the South Asian community (including Fijians, Indians and Sri Lankans) in the Lower Mainland and Fraser Valley of British Columbia reports that eight of twenty-six basic adaptation needs were of concern for the South Asian community. These included housing, health, mental health, English language training, employment, legal, family and social needs. Curiously, none of these key eight needs were identified by Fijians. However, the report states that "the Fijian finding should be viewed with caution as only three respondents, all Immigrant Representatives, answered for the newcomers" (ISS, 1993: 200).

While a program of research to address all eight areas of concern is beyond the scope of this thesis, focus on South Asian Fijian women can begin to address some gaps in health knowledge. By asking women directly what their concerns are and allowing them to speak for themselves, this research will

be able to shed light on the health and health care experiences of these women, contextualized within the immigration experience.

Additional rationale for the research comes from the gaps identified in the literature (Anderson et al, 1991; Dyck, 1992; Kulig et al, 1991; Palmer, 1991; Walters, 1992), revised health policy goals of the British Columbia government in seeking a broader definition of health (B.C. Min. Health, 1993b), and the researcher's investigation into primary health care in Fiji (Gillie, 1991; Gillie, 1992a and 1992b).

In general, the major findings documented in existing work are :

(1) women's own definitions of their health needs and priorities have received little attention despite an increasing emphasis on women's health issues and on community involvement in the development of health policy (Koblinsky, 1993; Walters, 1992);

(2) the problems emphasized by women are not the problems highlighted in government policies and proposals (Walters, 1992);

(3) immigrant women in particular face inequities in the health care system which create barriers to achieving health (Anderson et al, 1991; Kulig et al, 1991; Palmer, 1991; Payne, 1981); and,

(4) women's health experiences cannot be considered separate from the wider social, spatial and cultural context

within which they occur (Heller, 1986; Donovan, 1984; 1986; Eyles and Donovan, 1990; Dyck, 1992).

Despite the contribution made by this research in both academic and policy realms, knowledge of women's health concerns remains limited. This thesis begins to address such gaps by asking a specific group of women what their health experiences are, and focuses on the possibilities for South Asian Fijian women to achieve health in the social and spatial context of their everyday lives.

The conceptual basis for this thesis lies in the field of medical geography (Hayes, 1992; Eyles, 1993b; Dyck, 1992), with additional contributions from medical anthropology (Lock and Scheper-Hughes, 1990; Stephenson, 1993), and the sociology of health and illness (Coburn and Eakin, 1993; Walters, 1992). This thesis focuses on a rationale for a geographically informed approach to health research which considers health as a socially constructed phenomenon influenced by both local subjective experience of place and wider social processes.

The research design employs a qualitative framework based on open-ended depth interviews. Depth interviews are defined as exchanges where appropriate question and answer styles emerge during the process of interaction between the researcher and respondent, and where the researcher must link responses and meanings to a broad body of knowledge (Eyles, 1988). They differ from in-depth interviews in that they provide an opportunity to develop trust between researcher and

"researched" and increase the opportunity for transfer of expert knowledge from the participant to the researcher (Jones, 1985; Cornwell, 1988; Eyles, 1988). Qualitative research complements a social constructionist approach so that the meanings behind everyday conceptions of health and use of health services can be examined.

In the final analysis, the health concerns of South Asian Fijian women clustered around meanings and definitions of health, physical health, emotional health, the health care system, and women's roles as health care providers. The link between emotional and physical health, rooted in the immigration experience, was found to illuminate the socially constructed nature of health in place.

1.3 Chapter Outline

This thesis has five chapters. Chapter Two presents a history of South Asian Fijian peoples' experiences (Section 2.1) and sets the theoretical focus for this study on the geography of health and ethnicity (Section 2.2). A theoretical synthesis (Section 2.3) situates the thesis within a geographically informed social constructionism. The chapter concludes with a discussion of methodological considerations in the context of theory (Section 2.4).

A description of the research design, objectives, and methods is found in Chapter Three. Chapter Four contains profiles of individual women's lives which provide a link

between women's everyday life experience and their achievement of health in place. The results of the depth interview analysis are presented in Chapter Five. Meanings and definitions of health (Section 5.1) provide a basis for the discussion of the health experiences of South Asian Fijian women (Section 5.2). A discussion of the immigration experience as it relates to health in place, and a detailed discussion of participants' impressions and experiences as these relate to the achievement of health in everyday life, follows (Section 5.3).

A summary of the research, followed by conclusions and contributions are found in Chapter Six. Also addressed in this chapter are methodological considerations, as well as implications for health policy. Directions for further research are also suggested.

CHAPTER TWO: HEALTH AND ETHNICITY

This chapter reviews the substantive, theoretical, and methodological literatures around the geography of health and ethnicity focusing on the rationale for a geographical approach which is in turn informed by an interpretive social constructionism. Finally, methodological considerations are discussed in relation to the theoretical framework and in light of contributions from feminist literature. The chapter begins with a history of South Asian Fijian [1] migration to Canada and an overview of the health care system in Fiji.

2.1 The South Asian-Fijian Experiences: History, Migration and Health

2.1.1 History

Fiji is a nation of 300 islands with a total land area of 18,376 square kilometers, between latitudes 15 and 22 degrees South and longitudes 177 degrees East and 178 degrees West (Robertson, 1990: 2). Only one third of the islands are inhabited, the largest being Viti Levu, on which eighty percent (715,000) of the population of Fiji lives (Figure 2.1).

Prior to the arrival of Europeans and South Asians these Pacific islands were inhabited by approximately 200,000 melano-polynesians (Buchignani, 1977). The social and economic organization of pre-colonial Fijian society was based on subsistence agriculture and was modified according to ongoing conflict and alliance between different native groups.

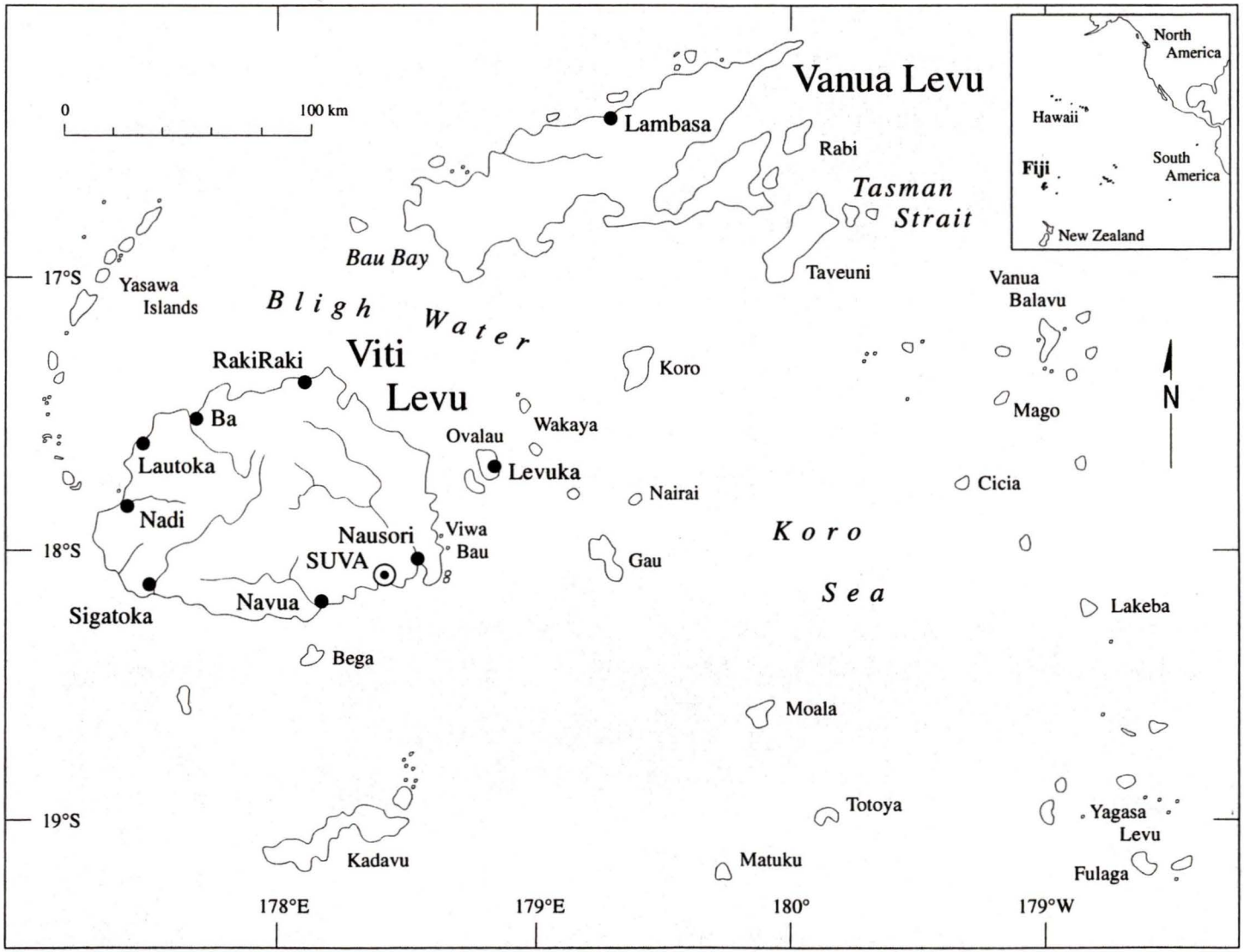


Figure 2.1 The Fiji Isands

This resulted in geographical variation in social relations and customary land tenure systems within Fiji, as no universal or exclusive system of land tenure or social organization developed in this dynamic environment (Buchignani, 1977; Farrell, 1974).

Between 1860 and 1870 the "white agricultural pursuits" (Buchignani, 1977) of the European planters who followed the missionaries to the Pacific islands placed stress on customary land tenure systems and on social relations with the indigenous Fijians. Indigenous Fijians chose not to work as wage labourers for the planters because their subsistence economy supported them adequately (Buchignani, 1977). It was not until the Fiji islands were formally ceded to Britain in 1874 (and the subsequent official objection of the first Governor of Fiji, Charles Gordon, to using indigenous Fijian labour) that South Asian labour was successfully imported from India around 1879 (Buchignani, 1977; Robertson, 1990).

According to Robertson (1990: 5) the indigenous Fijian component of the population in Fiji had higher death than birth rates from the time of European contact until 1921. At the time of cession to Britain in 1874, and prior to indenture and the influx of South Asian labour, the indigenous population of Fiji was reported to be 130,000. Three months after cession, a measles epidemic killed 40,000 indigenous Fijians (Robertson, 1990: 5). Indigenous Fijian growth rates did not increase until after indenture in the 1920s. During

the period 1876 - 1916 it was the immigration of South Asians that contributed to an increase in the annual growth rate of the population (Robertson, 1990: 7). Between the years 1879 and 1916, 60,553 South Asians arrived in Fiji to work in the sugar cane fields as indentured labourers (Ali, 1981; Farrell, 1974). After a five year *girmit*, South Asians were free to settle in Fiji, or by remaining another ten years in the colony, could also choose to be repatriated to India.

Conditions facing indentured workers were very difficult and are referred to by Buchignani (1977:84) as "abject poverty" and by Ali as

> narak or hell: there was illness, murder and suicide, overtasking, bullying and beating of labourers. Personal privacy and normal family life proved difficult to maintain in the environment of the coolie lines (1981: 22).

Most survived the conditions, however, and significantly, sixty percent of indentured labourers chose to remain in Fiji after serving the required period (Ali, 1981: 23).

The diverging cultural, caste, and linguistic backgrounds of these migrants from India were brought together into a social structure which is uniquely Fijian (Buchignani, 1977; Farrell, 1974). This unique social structure was the result of separation from traditional family ties, the more generalized use of one language (Hindi), the blending of castes, and intermarriage. There was an aura of force surrounding the conditions of indenture and according to Buchignani (1977: 88) "caste meant little in the face of

force, neither Hindu nor Muslim marriage customs were observed."

After the abolition of indenture in 1920, South Asians were able to establish family and social life more along their traditional lines (Buchignani, 1977). "Intermarriage, the prime indicator of Indian social distance became infrequent" (Buchignani, 1977: 100). South Asian religious and social associations were also formed (Buchignani, 1977: 98).

In addition to farming individual lease-holds, many South Asians became successful in business. South Asian Fijian success was also evident in the professions (Ali, 1981: 26). The economic success of South Asians was not matched socially or politically, however. Ali (1981) gives two reasons for this. First, colonialism encouraged racial compartmentalization and denial of certain services to all blacks. Second, each community operated insularly, so social practices kept the compartments sealed. For these reasons, interaction and interdependence were restricted to the economic sphere of activity. There was some increase in racial conflict in Fiji leading up to Independence in 1970 but the origins of this are to be found in group-based economic competition and the question of who would control post-independence governments (Buchignani et al, 1985). Immigration to Canada, which prior to 1965 had been virtually non-existent, increased after Independence (Assanand et al,

1990: 146). Ali (1981) states that the emergence of the Fijian Nationalist Party and the successes of Edi Amin in 1972 in expelling South Asians from Uganda instilled fear in the minds of South Asians in Fiji. While assurances from Fijian leaders as well as constitutional representation provided for the fundamental rights of South Asians, a sense of alienation from the political process on the part of South Asians was increasing.

2.1.2 Migration

In 1962 the Canadian government removed almost all racial and national restrictions from immigration regulations. This contributed to a shift from Anglo-European immigration to that of South and East Asians (Buchignani et al , 1985: 23). Political unrest in India, and political and economic tensions between South Asians and indigenous Fijians in Fiji during the 1960s and 1970s, led to increased migration from both countries. Perceived economic opportunities in North America and potential remittances to India and Fiji also served to increase migration to British Columbia. The point system - where economic viability, skills and education were made an integral part of the Canadian immigration selection process - as well as elimination of racial and national barriers, led to an increase in South Asian immigration from many source countries (Buchignani et al, 1985: 115; Buchignani, 1977: 162).

Fiji's Independence from Britain in 1970 provided the

first major impetus for South Asian Fijian migration to Canada (Table 2.1). By 1985 one out of ten Fijians had left Fiji (Buchignani et al, 1985: 138) to settle in North America, New Zealand or Australia. Of those who migrated to Canada, many remained in Vancouver (seventy-five percent) due to the city's role as a Pacific port of entry although small numbers (about 2000) did move to Edmonton and Toronto (Buchignani et al, 1985: 138).

TABLE 2.1

SOUTH ASIAN FIJIAN IMMIGRATION TO CANADA, 1972 - 1982

1972	1973	1974	1975	1976	1978	1979	1980	1981	1982	**TOTAL**
636	987	1530	2323	1081	552	518	637	699	818	**10,494**

Source: Adapted from Buchignani et al, 1985: 115

Outmigration from Fiji increased substantially after the *coup* of 1987. While the primary cause of the *coup* may be related to racial divisions and battles for political dominance between South Asians and Fijians, economic interests were also involved. These were mainly divided along traditional lines between groups of indigenous Fijians in the east and west of Fiji (Robertson and Tamanisau, 1988). While an inherently complex situation, the implications of the *coup* for outmigration were clear: racial uncertainty for South

Asian Fijians caused them to leave Fiji in large numbers. Since 1987 about five hundred South Asian Fijians have migrated to Canada annually and as of 1990 there were about 14,000 South Asian Fijians in Canada (Assanand et al, 1990) with 11,400 of those residing in Greater Vancouver (ISS, 1993).

Migration from Fiji to Canada follows a chain migration pattern (Buchignani et al, 1985) which allows for the maintenance of mutual aid and family support for new immigrants:

> It provides material support on both sides of the water, and lessens both the risks and costs of immigration. It also provides psychological security and a basis for information both for immigration and for beginning life here [British Columbia] (Buchignani, 1977:168).

Younger people, primarily young men, consider leaving their jobs in the hope of gaining a higher material standard of living (Buchignani, 1977: 157). These people have probably heard of greater economic prospects in Canada from their friends and relatives.

Many intangibles are also found at the heart of decisions to emigrate (Buchignani, 1977: 158):

> Although it is difficult to say how much the loss of these things is actually considered before they are given up, intangibles like the possible loss of a defined feeling of place and of a secure self identity must be factors in immigration choice.

For example, older married women are often reluctant to leave

Fiji, because in Fiji they have had a very established life and "a large part of it was defined by dense relationships with both people and places" (Buchignani, 1977: 158).

Older people (especially women) face substantial risks when immigrating. Buchignani (1977: 161) states that the sacrifice of status, easy pace of life, the security of a supportive network of friends and relatives, favourite foods and favourite places is weighted against relative uncertainties of life in Canada and the relative prospects of remaining in Fiji in relation to future job prospects for children (in competition with indigenous Fijians) and concern for government activities.

Women's roles in immigration differ from those of men. This is probably due to the "limited amount of independent decision making Fiji Indian women can carry out re immigration" (Buchignani, 1977: 161). This limited role in decision making in immigration extends from the well-defined roles of men and women in South Asian Fijian culture. Buchignani (1977: 162) states that most women emigrate in the context of the family either being sponsored by their husbands or nominated by relatives.

Women emigrating alone, however, often do not have access to familial or social support networks, or due to breakdown in these networks usually due to divorce, lose what access they may have once had.

2.1.3 Health And Health Care

Fiji's scattered islands and limited infrastructure make cost-effective provision of health care services difficult (Fiji: Ministry of Health, 1991, 1989). The current health care system follows the primary health care model promoted by the World Health Organization (WHO, 1977, 1986) as stated in the Alma Ata Declaration of 1978 and as articulated in the goals of the Health for All By the Year 2000 program. It operates in three geographic divisions and is designed to be comprehensive, accessible and decentralized from the larger islands to the entire nation (Figure 2.1). Each division provides public health services and a Divisional Medical Officer (medical doctor) is in charge of a team comprised of the divisional health sister (nurse), divisional health inspector, and support staff. There are nineteen subdivisions with this pattern of reporting being repeated in all of them. The nineteen subdivisions are further divided into seventy-one medical areas, each of which has one health centre.

Health centres are usually small rural units although some larger centres serve growing peri-urban areas. For example, the Valelevu Health Centre, approximately ten kilometres outside Suva, was established in 1981 to take the pressure off urban hospitals in the provision of primary health care and outpatient services. This larger health centre employs five doctors, seventeen public health nurses and three community health workers and serves a population of

45,700 (Gillie, 1991). A good example of the smaller, rural health unit is the Namuamua Health Centre in the Namosi District, employing one doctor and two nurses and serving a population of 5,000. Health centres are the focal point for preventative care, primary health care and health education and promotion in Fiji. Further, they play a key role in health care delivery to women. Women's health concerns are addressed through the maternal child health element, immunization programs, and nutrition counselling as well as indirectly through other health promotion schemes, such as anti-smoking and healthy eating campaigns. While strides have been made in improving health care delivery to women, there are gaps in primary health care delivery and in the planning and evaluation of programs. For example, consistent compilation of accurate vital statistics has not occurred and is particularly problematic in rural areas. The Fiji Ministry of Health points out that communication difficulties in rural areas can exacerbate the difficulty of obtaining up-to-date and accurate information on births and deaths, diseases and other vital information regarding agricultural production and women's activities in particular.

In addition to medical care, health facilities provide a place for women to legitimately meet and socialize outside the home. As Gill (1988: 98) states,

> health centres and out-patient departments are frequently the only place outside the home where a young married woman or single woman, or young mothers are able to go commiserate

> with other women friends. It is a legitimate way to get out of the settlements without criticism.

The roles of health care facilities as social settings are important to an overall understanding of women's conceptions of health, illness and disease. For example, the role of the health centre in Fiji goes beyond that of a medical facility to serve social needs as well. Similarly, Maori in New Zealand are more concerned with finding a doctor and clinic that their kin and community like, and will travel considerably farther than the nearest health facility to fulfill this need (Hays et al, 1990).

Private doctors practice in Suva and in some larger towns, and people who can afford to utilize this more western style of medical care, do so. Specialist referral is generally available only in the larger cities of Suva, Nadi and Lautoka, although referrals within the primary health care system are more common. Serious cases that require advanced medical equipment and diagnostic testing are referred overseas, often to New Zealand or Australia. This referral is usually restricted (in fiscal terms) to locals who can afford such care, resident expatriates with special medical insurance, or to children who are sponsored by aid or religious organizations. To date there is no universal health insurance in Fiji to cover such expenses for the average citizen.

2.2 The Geography of Health and Ethnicity

Jacques May, a physician interested in the geographic context of disease, described three categories of factors, or 'geogens', comprising the physical, human (social), and biological dimensions of human health. These 'geogens' illuminate the interaction and interrelationships between many possible causative factors and pathological agents affecting human health, in both the physical and social environments. May asserts that disease is a multiple phenomenon occurring only when a variety of factors coincide in time and space (1950).

When May examined health behaviours and outcomes in different cultures, however, he used western, scientific medical knowledge as his basis for analysis. This research focus was the precursor to disease ecology in medical geography and was also firmly rooted in western philosophies of modernizing the developing world through technology transfer. Consequently, May often reduced perceived poor health conditions or incidence of certain diseases (usually occurring outside of Europe and North America) to the "primitive" activities of less developed cultures (1950: 41). This approach tended to problematize health related behaviour which did not conform to the new and expanding tenets of western biomedicine. May stated that certain "unsanitary" or "unhealthful" practices contributed to social, economic and cultural "backwardness" (1950). While modern day scholars may

justifably label May's work as at the very least determinist, and definitely ethnocentric, if not racist, it represents an initial recognition that ill-health is caused by other than the biological.

In recent decades, broader definitions and models of health have emerged as alternatives to the biomedical disease model generally (BDM), to disease ecology in geography, and to disease focused approaches across the social sciences. The BDM has traditionally focused on a symptom-producing lesion with one underlying pathological cause (White, 1981) while disease ecology has been concerned with the spatial patterning of disease and disease mapping. More recent definitions consider health as a resource for everyday living rather than just the relative absence or presence of disease (WHO, 1977, 1986; Epp, 1986), and have enabled social science researchers to develop new research questions around health and ethnicity.

In response to these broader definitions of health, geographers have focused increasingly on the interaction of social, cultural, economic and physical factors in the production of health and illness. The roles of space and place are being asserted in the context of human everyday experience (Dyck, 1992; Jones and Moon, 1993; Kearns, 1993, 1994). A person's place in the world and all the factors which contribute to and affect this, and the ability of a person to change and act in a given "lifespace" have direct impacts on health and well-being. For example, immigrant women may have

been socialized into roles which fulfill a certain "place" or which guarantee specific functions in their country of origin. These roles may be adapted or changed upon immigration due to cultural, economic political and social changes. Thus the places of women change, not only geographically and literally, but also figuratively. Both can and do impact upon health and well-being.

Past research in geography has tended to reduce the health experiences of immigrants and ethnic groups to cultural differences, and has ignored political, economic and social factors (Donovan, 1984, 1986, 1988; Eyles and Donovan, 1990). Donovan is explicit in her call to consider health and ethnicity in the context of social, political and economic constraints, and not just disease. For example, in a critique of *The Black Report*, Donovan (1988: 180) refers to data on Britain's black population stating that the "evidence was scanty and of poor quality." Donovan uses the term "black" in a political sense, to refer to all people of Asian and African background living in Britain. Donovan (1988) notes that very little research has considered the views of black people or the black community about their health or modes of coping but has focused on the most common diseases of ethnic minorities such as rickets and tuberculosis.

There has been similar tendency in medical anthropology to reduce health, disease and illness issues to culture and to ignore social categories. Lock (1990: 237) elaborates on

this:

> It is suggested that medical anthropologists who ignore the complexity of social categories and whose focus is limited to the cultural construction of illness and the expression of distress are in danger of reinforcing a notion of the "quaint ethnic", a stereotype to which the concept of multiculturalism is often reduced.

Researchers in medical anthropology are also critical of biomedical approaches to the study of health and illness, particularly women's illness, because it has tended to subsume folk categories of distress (such as "nerves") under western medical categories such as depression (Lock and Scheper-Hughes, 1990: 70). In biomedicine "the meanings and causal explanations attributed by individual patients to their distress and the social context of their lives remain irrelevant. . ." (Lock and Bibeau, 1993: 156). While it is unfair to assume all medical practitioners ignore social and cultural factors as they interact with health (Lock, 1990; 250-251), rarely does the diagnosis, therapy and outcome approach solve underlying problems which are constantly reinforced in the social world.

The sociology of health and illness also provides opportunities to investigate women's health issues in a broader, more holistic framework. The sociology of health and illness provides insights into the social constructions of definitions of health, illness and disease and approaches the study of health within the academic and societal context in which it is embedded (Coburn and Eakin, 1993). This approach

in sociology differs from a "sociology in medicine approach" which has to date concentrated on applied research directly tied to the study of medical issues, institutions and health care delivery systems.

In relation to the sociology of health and ethnicity, Edginton (1989: 107), like Donovan in geography and Lock in anthropology, reiterates the warning to researchers not to reduce health to culture, or even worse, to the biological category of race. Further, Edginton, (1989: 107) states that it is more appropriate to "use categories that will help identify the social basis or cultural differences and not concepts developed to foster an ideology of racial superiority."

Recent work in medical geography provides a bridge between disease ecology and emerging approaches to the study of health and ethnicity. Gesler (1991) examines the merging of cultural and medical geography and the importance of both cultural and spatial aspects of health. He acknowledges that "geographic studies of disease had a strong cultural component from the very beginning" (1991: 7) analyzing population, environment and behavioural aspects of disease as well as considering cultural systems, cultural ecology and the importance of place. But these studies retained a distinctly quantitative focus and focused primarily on spatial distribution, accessibility, and utilization of medical personnel and facilities (Gesler, 1991). Central place theory

and distance decay models provided the conceptual bases to this research. Gesler (1991: 8), in discussing the increasing complexity and utility of quantitative methods in medical geography, applauds technological advances but states

> something seems to be missing in these increasingly complex investigations: they begin to look like technological fixes. Like biomedicine they often place undue emphasis on technique rather than on the human element in health care.

The consideration of medical and cultural geography in his volume emphasizes the importance of ethnographic studies as well as the development of complementary quantitative and qualitative research methods which enable researchers to view health care delivery in its entire societal context.

Foggin et al (1989, 1994) have attempted to frame their research within a socioecological framework originally asserted by Anderson and others (1976). This research has focused on the health status and risk factors of semi-nomadic populations in Mongolia within the context of providing effective preventive health measures in rural areas, as well as issues of acculturation and health among Aboriginal peoples in Canada. Foggin contextualizes health status as a dependent variable influenced by environment, health services,

individual and community characteristics and the social-economic-political system. Foggin states that the associations between risk factors and health status indicators illuminated by the socioecological research framework are

informative and instructive, and particularly useful in the assessment of appropriate health services (Foggin et al, 1994).

Most recently, the "post-medical" geography proposed by Kearns (1994: 115) suggests that geographers use an approach which places the entire person in the context of everyday life, which in turn shapes disease and illness. Jones and Moon (1987) encourage researchers to "go outside the body" and to develop alternative social and environmental perspectives on health, as does Dyck (1992) in encouraging health research in geography to go "beyond the clinic to that which forms the material and social circumstances of people's lives." This expanded focus on health is particularly important to Canada as a multicultural nation, where immigrants tend to experience more difficulties in receiving the health care than other Canadians (FPTWGWH, 1991; Heller, 1986; Koehn, 1993; Stephenson, 1991; 1993). Increasingly, research in health geography is acknowledging the varied nature of definitions of health and of the space and places in which health experiences occur. Rather than reducing health experiences to cultural differences or simply studying disease incidence among ethnic minorities, recent research is attempting to show that societal structures in combination with the migration experience may produce varied experiences of health for people of differing cultural backgrounds.

Dyck's recent work in health geography examines the

potential contribution of a social and contextual approach to the health experiences of immigrant women (1990; 1992; 1993; 1994; 1995). She explores the relationships between the individual immigrant woman and her health experiences in relation to social, economic and political factors in western society, and outlines the utility of health geography in illuminating links between micro and macro levels of analysis (see Section 2.3).

The concept of cultural safety is also critical to new directions in health research as questions of health for whom and by whom in multicultural societies in different localities are addressed (Dyck and Kearns, 1994). Cultural safety is defined as the opposite of cultural risk which occurs when "people from one culture believe they are demeaned and disempowered by the actions and [health] delivery systems of people from another culture" (Ramsden and Spoonley, 1993: 164 in Dyck and Kearns, 1994). The concept of cultural safety originated in Aotearoa/New Zealand and is contextualized in post-colonial cultural politics surrounding Maori-Pakeha (white people of European descent) relations. Recent efforts to re-acknowledge Maori culture are exemplified in efforts to train medical and health personnel in cultural safety. Specifically, health professionals will henceforth be trained to have a more critical understanding of colonial structures and their impacts on the contemporary Maori. Also, ethnic sensitivity is now the orientation of health education

curricula in Aotearoa/New Zealand (Dyck and Kearns, 1994).

Implications of cultural safety for medical geography include the challenge to address research methods and find the "medico-centric" or "colonial baggage" contained therein and reform approaches to cross-cultural research. The power dynamics of the research exchange must be addressed including the "historically constructed forms of oppression" (Dyck and Kearns, 1994) that may be evident in the background of the researcher. This research provides an example of the inherent dilemma facing cross-cultural researchers. Depth interviews, a qualitative research method, were chosen as the preferred data collection method in order to involve 'ordinary' women from the community in the research process. However, such methods may be intrusive and may not adequately deal the with the "gap", or political distance between the researcher and the "researched", in the post-colonial sense (Moss, 1995). It is a challenge, therefore, to ensure research in medical geography remains culturally safe.

Recent work in medical anthropology also informs this thesis. In an in-depth look at the health strategies of Indo-Fijian (South Asian Fijian) women in Fiji, Gill (1988: ii) is careful to take into account the context of Indo-Fijians as descendants of indentured labourers, and who "have had to adapt, to regularize their lives through situational adjustment". This idea, iterated also by Buchignani (1977) in understanding the current migration situation of Indo-Fijians

to British Columbia, is key to a fuller understanding of the use of the health care system in British Columbia by South Asian Fijian women and how health concerns play a role in women's everyday lives. Gill (1988: ii) states that in Fiji:

> Indo-Fijians do not distinguish between medical systems; their medical system is Indian in its ideology but lacks the practice of the therapies of professionalized Indian medical systems; it has retained religious healing, reconstructed and synthesized folk healing traditions from many parts of India, as well as adding elements from Fijian healing. While it is also Western in its use of professional therapies, it lacks the ideological foundations of biomedicine.

This varied systemic experience may have an impact on the expectations that South Asian Fijian women have of the health care system in British Columbia.

Recent anthropological research on nerves as a folk idiom for stress (Nations et al, 1988), and metaphor for the expression of distress (Migliore, 1993), also illuminates possible linkages between political, social, cultural and economic factors and physical distress among immigrant and ethnic minority women in North America. Lock (1990) and Dunk (1989) use the concept of 'nevra' or 'broken nerves' as a critique of multiculturalism in Canada, finding that nerves are "boiling over" among Greek women living in Montreal and that these experiences are intimately linked to immigration with causes most often attributed to social and political variables). Taylor, a geographer, (1989 as cited in Lock and Bibeau, 1993: 161) speaks of "moral topography", a social

space of shared values which sustains our sense of purpose and well being. Taylor argues that Greek women in Montreal, and possibly other immigrants elsewhere in Canada, are suspended between moral topographies.

Similar shocks and adjustments may also occur in the health care experience of immigrant women in the form of "healthshock". Bhayana (1991: 28) defines healthshock as

> the interaction that occurs between the health care provider and the health care consumer when each has different cultural backgrounds and experiences. Unlike culture shock the reaction is bilateral and has as great a potential to be positive as well as negative.

The parameters of healthshock are: (1) the meeting of different health attitudes, beliefs, and practices; (2) the nature of the exchange between health care provider and consumer; and (3) the effect of the first two on certain members of society, such as immigrant women and seniors (Bhayana, 1991: 28). While the term healthshock refers specifically to the patient-practitioner relationship, the idea may also be useful in referring to the broader health experience as well.

In a study of women in Hamilton, Ontario, Walters (1992) found that women's major health concerns did not always match those identified in health policy. What is particularly interesting about Walters' study and what relates it particularly well to this thesis, is its canvassing of 'ordinary women'. 'Ordinary' women's health concerns are

often different to those prioritized by key informants and medical personnel (Redman et al, 1988; Walters, 1992).

In particular, and in light of expanding perspectives in both health geography and medical anthropology, it is important to note that the women in Walters' study spoke of:

> the stress associated with the family responsibilities, occupational demands and worries about money and about violence. It may be that the roots of the problems women report lie in the social problems they identify and that they require initiatives outside the health care system (1992: 373).

In sociological circles, "while viewed by some as inherently individualistic, the concept of stress can also be a powerful tool linking social structures with groups or individual physiological response" (Coburn and Eakin, 1993: 89). When spatial and cultural factors are considered in relation to the social dynamics of worry, stress and nerves in everyday life it may be found that these are major factors in women's health.

A gap exists in health information on the different ethnic groups of Canada at both academic and government levels (Edginton, 1989: 109). Therefore the participation of women (Dyck, 1992; Walters, 1992) from varied cultural backgrounds in health research may go a long way in identifying social and spatial issues surrounding the health of Canadian women. By involving women in the formulation and implementation of policy, community-based data will better reflect the actual picture of women's health, whether the women are new

immigrants from Fiji, Anglo-Canadians, or Aboriginal women.

2.3 Theoretical Perspectives: Integrated Social Constructionism

Emerging perspectives in health geography are informed by a relational view of space and place (Eyles, 1993b), and are concerned with the social construction of health in place (Dyck, 1995). Social constructionism illuminates a middle ground between micro and macro levels of analysis through the consideration of the impact of wider social processes on individual health experience. It is an approach which seeks to place the entire person in the context of the everyday life which shapes disease and illness.

The origin of social construction as a theoretical base may be found in the work of Berger and Luckman (1966) in their treatise on the sociology of knowledge. The basic contention of the social constructionist argument is that "reality is socially constructed" (Berger and Luckman, 1966:1). The knowledge which guides conduct in everyday life, and which is referred to by these writers, is the clarification of reality as it is available to the common sense of the ordinary members of society (1966: 19). Berger and Luckman refer to the processes of institutionalization, legitimation, and objectification (through language) through which human beings create an objective reality. The socialization process reinforces the above processes and creates the conditions in

which subjective experiences take place. By examining society as the product of its social constructions, the institutions which legitimize behaviour may be viewed as the creators of that behaviour or of the structures which facilitate or constrain human agency. These institutions include health care systems, legal systems, education systems, political systems and so on. Proponents of constructivist approaches

> share the goal of understanding the complex world of lived experience from the point of view of those who live it. This goal is variously spoken of as an abiding concern for the life world, for the emic point of view, for understanding meaning, for grasping the actor's definition of a situation (Schwandt, 1994: 118).

In order to understand the relationship between institutions and individuals it is necessary to understand how certain knowledge is created and used by people in their everyday lives. For the purposes of this research, many different types of knowledge become important, for instance medical (scientific) knowledge, traditional knowledge (in the sense of alternative medicine or healing), and cultural knowledge. Berger and Luckman (1966: 20) state that the method they consider best suited to clarify the foundations of knowledge in everyday life is that of "phenomenological analysis, a purely descriptive method and, as such, "empirical" but not "scientific" - as we understand the nature of the empirical sciences." Schwandt (1994:118) states that to "understand the world of meaning one must interpret it."

Thus the emphasis on the development of qualitative methods of interpretation, in this case, depth interviewing and subsequent major themes analysis. The basic tenets of the constructivist paradigm are as follows: (1) it employs a relativist ontology, where local and specific realities are constructed; (2) it employs a transactional and subjectivist epistemology where the investigator and the object of investigation are linked and findings are created as research unfolds (thus erasing the classical distinction between ontology and epistemology); and (3) it employs a hermeneutical and dialectical methodology with the final aim of distilling a consensus construction that is more informed than any preceding construction (that is, the construction of any one individual or that of the researcher) (Guba and Lincoln, 1994). The implications of the above for the present study encompass a meeting of theory and method, and a meeting of researcher and participants, for the purposes of determining and understanding health experiences.

Social construction is also associated with interactionist perspectives through an emphasis on how "subjective definitions of social reality are constructed and how this reality is experienced, negotiated and described by different social actors" (Litva and Eyles, 1995). Interactionism focuses on the individual and the processes by which people come to understand themselves as being healthy, anxious, or at risk (Litva and Eyles, 1995). Interactionism

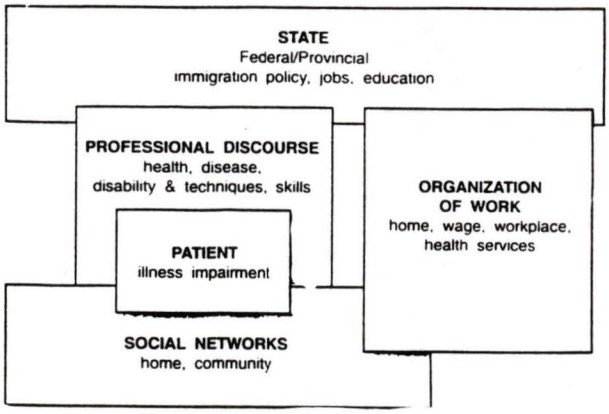
shares the same intellectual heritage as social construction, (Schwandt, 1994), which proposes that people actively construct understandings of themselves using the evidence which comes from their interactions and negotiations with others (Cooley, 1964 as cited in Litva and Eyles, 1995). Social construction parts company with interactionism at the level of unit of analysis, where it moves from the individual mind and cognitive processes to the "world of intersubjectively shared, social constructions of meaning and knowledge" (Schwandt, 1994: 127). Constructivist approaches also focus on human beings as agents, as actively engaged in the construction of knowledge and social life, and thus actively engaged in social change.

Social constructionist approaches are not new in geography generally, and have proven useful in the literatures of development, urban politics, urban form, and within structurationist studies of place (Unwin, 1992; Cloke et al, 1991; Eyles, 1993b). Structurationist approaches also have roots in Berger and Luckman's work on social construction (Cloke et al, 1991: 95), and the concern with the "everyday", the "lifeworld" and with "common sense meanings" which have informed a recasting of phenomenological studies of place in social geography (after Alfred Schutz, as cited in Cloke et al, 1991: 85). Social constructionism has yet to be developed extensively in health geography although Kearns and Joseph (1993) suggest developing theoretical constructs to

contextualize space and place which are similar to those used to contextualize social phenomena. Further, Dyck's (1992) work with immigrant women explores the social construction of health in place. Dyck states that "understanding the social construction of women's lifeworlds and means of agency requires knowledge of their functioning relationships in everyday life" (1992: 247). This thesis is guided by the conceptual framework developed by Dyck (1992) which situates the experience of women's health and illness in the context of their everyday life. The inherent spatiality of social life provides "a valuable avenue for developing knowledge about how 'broader' power relations and local contextual factors interweave in constituting the resources available to the immigrant woman" (Dyck, 1992: 245). By fostering awareness of the "settings of interaction" in immigrant women's lives, discovery of the meaning of health as part of cultural knowledge is facilitated (Figure 2.2).

FIGURE 2.2

CONTEXTS OF HEALTH CARE KNOWLEDGE



Source: Dyck, 1992 (Adapted from Smith, 1986).

Each setting or place in the model - the state, professional discourse, the organization of work, the role of patient, and social networks - affects the ability of immigrant women to fulfill their health needs (Dyck, 1992). For example, immigration policy is important in determining whether or not a person is able to access the benefits of an extended family, or whether women may be dependent upon their children or their husband's family for their well-being (Koehn, 1993). The possibilities for gainful employment or education are crucial. Many immigrant women are forced to begin to work outside the home due to financial stress, often with no relief from the ongoing "home work" burden (Waxler-Morrison et al, 1990). All of these factors may in turn, impact directly on women's health. Professional discourse and access to the specialized knowledge of medical professionals play an important role in overall health, and the treatment of

specific illnesses and diseases. Social networks may mediate between the above settings and may or may not provide a supportive structure for the maintenance of good health. The "patient" (as defined in the model) or the "woman", interacts in all of these settings in her everyday life in one way or another. These settings create the space in which health is defined and experienced.

The socially constructed settings in the model are not mutually exclusive and allow for consideration of components not addressed in conventional analysis. Dyck (1992: 239) citing Pappas (1990), states that in addition to "omissions of political economy and gender in conventional (biomedical) analysis, racial power differentials also tend to be ignored in such explanations."

According to Eyles (1993b: 114) convergence in all medical geographic approaches has occurred through "the asking of welfare questions from different vantage points." This convergence is even more important to an evolving social constructionism which, in the context of health promotion and preventive health strategies proposed by governments, will uncover meaning informed by the expertise of research participants through qualitative research. Results from such research provide a key contribution to health knowledge.

In summary then, "the task of research, is therefore, to uncover the nature of the social world through an understanding of how people act in and give meaning to their

own lives" (Eyles, 1988: 2). This research approach in health geography is based upon socially constructed understandings of health, and assumes immigrant women have the "expert" knowledge of their own health experiences and concerns. In such an approach one realizes that while "disease is a necessary category in medical geography, it is not a sufficient one" (Kearns, 1994: 113).

2.4 Methodological Issues

Depth interviews are employed in this study because they are particularly useful in finding out about people's everyday life experiences in detail, and because they enable "thick description" of subjective understandings of society (Denzin, 1989: 82). Depth interviews can also affirm the importance of the individual experience without denigrating the possibility of community and collaboration (Siedman, 1991). This latter point is relevant to social constructionism, which seeks to illuminate the individual experience in light of broader societal influences, and to the research questions asked in this study which seek to place individual experiences of health into the wider context of immigration and history.

Qualitative methods, including depth interviewing, necessitate a complex interpretation of feelings and actions. This process begins in the initial stages of research design, and in the case of a social constructionist framework, necessitates attention to the constructions, interpretations

and roles of both researcher and participant(s). This approach acknowledges the interconnectedness of research relationships, and considers the researcher part of the process. The researcher must become a "flexible instrument" who can respond to situations with skill, tact, and understanding and develop skills to minimize distortion in the information produced and presented during the data gathering process (Jones, 1985; Mostyn, 1985; Seidman, 1991).

In order to address concerns of rigour in qualitative studies researchers have adopted terms which mimic the quantitative concepts of validity and reliability (Jones, 1985; Lincoln and Guba, 1985; Miles and Huberman, 1984, 1994; Mostyn, 1985; Siedman, 1991). Examples of such terms include trustworthiness, credibility, transferability, dependability and confirmability. Whatever terms are chosen by qualitative researchers to confirm the "truth" of their findings, depth interviews may be structured to enhance "validity". One way of addressing validity and reliability in qualitative research, and ensuring that meaning remains as intact as possible through the research process, is through triangulation. By employing various methods of data gathering within the same study, or by analyzing the data several different ways, researchers are able to "verify the repeatability of an observation or interpretation" (Stake, 1994: 241). Equally important, "triangulation serves also to clarify meaning by identifying different ways the phenomenon

is being seen" (Flick, 1992 as cited in Stake, 1994: 241). In this study, triangulation was attempted through redundancy of data gathering methods. Information was sought from three sources: (1) service providers, (2) individual women, and (3) focus group discussions. Multiple sources were sought to provide different perspectives on the same research questions (after Flick, 1992), and in order to gather as much information on the topic as possible so as not to "miss" any valuable contextual information.

The goal of interpretation of depth interview data is to present how "meaning is anchored in the stories people tell about themselves" (Denzin, 1989: 63). Denzin goes on to say that interpretation must "illuminate" and this may only be done when interpretation is based on materials that come from the world of lived experience. The goal of interpretation is to locate experience in social situations and record thoughts, meanings, emotions and actions from the subject's point of view. These events are historical and relational, that is, they unfold over time and record the significant social relationships that exist. They are in effect, "lived history" (Denzin, 1989: 64).

Denzin (1989: 57) refers to the process of interpretation as involving "bracketing" or isolating the key elements in stories. The search for "universal singulars" which denote individual stories as both like, and not like, any other story told by any other person who may have experienced the

phenomena in question, is important to the interpretive process. Constructionist interpretive style is based upon triangulated empirical materials that are trustworthy and which adhere to constructionist terms of validity and reliability (Lincoln and Guba, 1985). Constructionist approaches retain some degree of attention to the "canons of good science" (Denzin, 1994: 508) through a commitment to methods and procedures that will increase a text's credibility. Feminist, postmodern and poststructuralist theorists criticize this paradigm for its lack of ideological rigour although according to Lincoln (1990) constructionists are increasingly exploring practices which address moral, ethical, and political dimensions of social research.

Exploration of certain political and ethical factors associated with social research was also necessary in this study in order to examine the role of the white outside researcher and the goal of empowerment of research participants. Feminist literature in geography (Dyck, 1993; England, 1994; Kobayashi, 1994; McDowell, 1992a, 1992b, 1993a, 1993b; Moss, 1995; Nast, 1994; Schoenberger, 1992; Shaw, 1995), and outside the discipline (Gelsthorpe, 1992; Oakley, 1981; Ramazanoglu, 1992; Stacey, 1988; Strathern, 1987), and critiques of these literatures (Eyles, 1993a; Hammersley, 1992), are useful in elaborating upon issues which may benefit from analysis of gender, political, economic, social or cultural asymmetry. Although feminist approaches are not well

developed in the geography of health, feminist approaches have been very successful in other areas of geography, for example social and cultural geography (McDowell, 1993a, 1993b; Monk, 1994). In addition, feminist approaches as part of health geography are emerging (Dyck, 1995; Litva et al, 1995), and the goals of feminist research, as goals of "socially responsible" research, also apply to this study. It is in this context that research methods employed in feminist research and the concept of empowerment are discussed below.

Empowerment, in terms of this thesis research refers to any experience by researcher or researched which facilitates understanding and the ability to better deal with everyday life, especially concerning health. For example, finding an agency where a public health nurse speaks Hindi, or experiencing an "unburdening of the mind" may constitute empowerment. Opie (1992: 64) refers to an "in-built therapeutic dimension" in the depth interview research process, which, when used reflexively enables participants to reflect on and re-evaluate their experience as part of the interview process.

Feminist theory embraces empowerment as the goal of feminist participatory research in attaining political action on the part of research participants or disempowered groups (England, 1994; Moss, 1995; Opie, 1992). Empowerment may result from a "breaking down of power relations between the researcher and the 'researched' as well as in society at

large" (Moss, 1995), and is linked to feminist research through a larger human rights and social justice literature concerned with structural inequalities and the "politics of difference" in society (Smith, 1994; Young, 1990). Further, according to Dyck (1993:53),

> The perceived close connection between research and political action in feminist work makes it particularly important to be reflexive about the research process within which feminist knowledge is produced.

That is, consideration of hierarchy in the research relationship must take place, with self-critique providing one way of muting bias by creating awareness of how the relationship between researcher and participants is framed (McDowell, 1992b; Bonnett, 1994; Nast, 1994).

It must be recognized that empowerment in the research process is a two-way street, involving empowerment of the researcher as much (or more) than those being researched. It is not sufficient to assume that empowerment, as self-determination or catharsis, will take place simply because research is designed with this in mind.

Depth interviews, while providing avenues for participation and empowerment, have also been criticized for being intrusive, and for encouraging the assumption that health is an individual matter, separate from the social, economic and cultural factors which define health and illness behaviours (Dyck and Kearns, 1994; Nast et al 1994; Jackson, 1993). Focus group discussions may be useful in supplementing

information from individual interviews on community knowledge, beliefs, attitudes and perceptions. Supplementing depth interviews with focus groups may be one way of addressing Jackson's (1993) concerns about the cultural individualism inherent in research methods, and may address issues associated with the broader social units within which health, illness and disease behaviour are socially constructed.

In this particular research, depth interviews are consistent with the theoretical orientation used. The fact that the research involves immigrant women makes it necessary to examine the role of the outside researcher, and to acknowledge political, social and economic distance in the research relationship. It makes sense to choose methods which support an interpretive theoretical approach and have as a final goal, a critical look at the ways health, illness and disease experiences are socially constructed in the everyday lives of immigrant women.

2.5 Summary

The history of South Asians in Fiji and more recently, in British Columbia provides insight into the social, economic, and cultural aspects of the immigration experience. An understanding of where South Asian Fijian women have come from, in both a spatial and social sense, enables a more complete examination of their health and health care experiences in Canada.

The context for this research is provided by broader approaches to health research in health geography, with contributions from medical anthropology, and the sociology of health and illness. The exploration of broader definitions of health, and research avenues which are concerned with the role of space and place in the social construction of health, contribute to evolving theoretical perspectives in geography. Health geography provides the opportunity to study health and ethnicity in the holistic context of everyday life and wider social processes, not simply in terms of cultural differences.

Social constructionism provides a useful framework within which to examine health in place in the context of the everyday lives of individual immigrant women. Social constructionism provides a link between the micro (individual) and macro (societal) level of analysis, and illuminates local experience in the context of wider social processes. Social constructionism has yet to be developed extensively in health geography although Dyck (1992) provides a conceptual framework which situates the experience of immigrant women's health and illness in the context of their everyday lives.

Depth interviews are employed in this study because they are particularly useful in finding out about people's everyday life experience in detail. Issues of rigour, validity and reliability are addressed through triangulation and the interpretive process inherent in a constructionist approach.

Concerns about the role of the outside researcher and empowerment of research participants are informed by interpretive feminist literature in geography generally, and emergent feminist approaches in health geography.

In summary then, this research endeavors to contribute to health knowledge through the examination of health experience in an emerging conceptual framework, that being a social constructionist health geography. A description of the research design, objectives and methods employed in this research follows in Chapter Three.

CHAPTER THREE: RESEARCH DESIGN AND METHODS

This chapter outlines the research design and methods employed in this research. Section 3.1 presents the objectives of the research. Section 3.2 describes the study area and its relevance to recent immigration patterns and the past experience of the researcher in Fiji. Section 3.3 details the sampling process and introduces service providers and individual women. Section 3.4 discusses data collection, the interview checklist, depth interviews, and issues surrounding focus group discussions. Section 3.5 details the methods of analysis which were comprised of transcription, coding, and major themes analysis.

3.1 Objectives

The objectives of this research are threefold. First to document the health concerns of South Asian Fijian women living in Greater Vancouver. Second, to investigate the links between perceived health status and participants' perceptions of the immigration experience. Third, to investigate links between ethnicity and health in place for this particular immigrant group. The research also has a dual purpose of involving immigrant women in the research process, and informing health policy.

Addressing these objectives will help to illuminate how South Asian Fijian women define health and experience access to health services. In turn, these findings will contribute

to understanding South Asian Fijian women's perceptions of place and health, and cultural change. An attempt will be made to place these issues and experiences within the context of women's everyday lives and current British Columbia health policy (e.g., *New Directions*).

3.2 The Study Area

The research focused on the Greater Vancouver area of British Columbia (Figure 3.1) for two reasons. The first relates to recent immigration patterns of South Asian Fijians to that area of the Province, and the second relates to the researcher's life experience in Fiji and her subsequent personal history which provided an entrée into the South Asian Fijian community in Vancouver.

Over the past decades the ethnic composition of western Canada has become increasingly diverse (Anderson et al., 1990). Many immigrants now come from South and Southeast Asia, Central America and the Caribbean, whereas prior to 1970 most came from Great Britain, Europe, the United States, Australia and New Zealand (SACM, 1992). Migration from Fiji to Canada increased after Fiji's Independence in 1970 and especially after the 1987 *coup* due to increasing political, economic, and racial tension (Assanand, et al, 1990). About

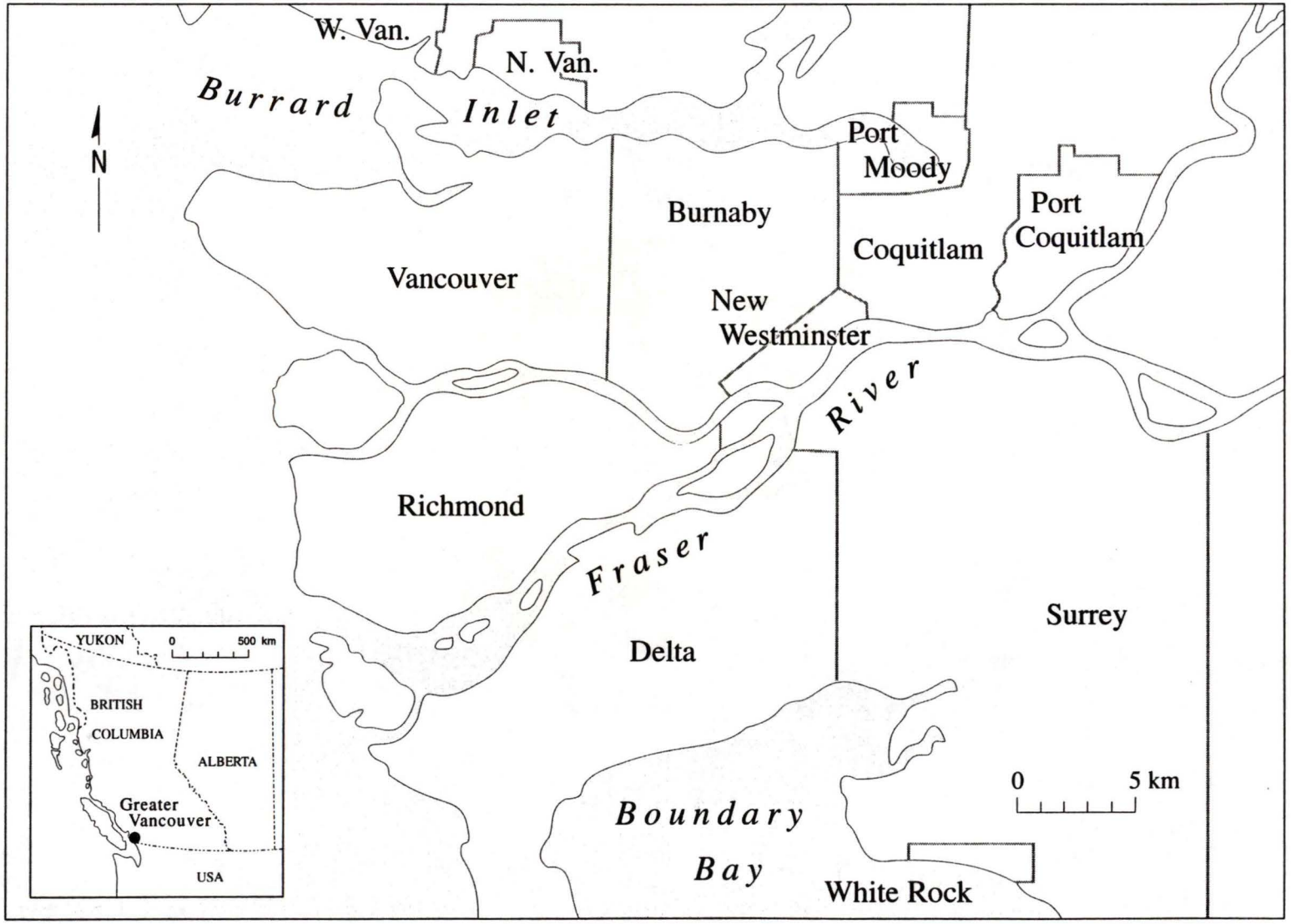
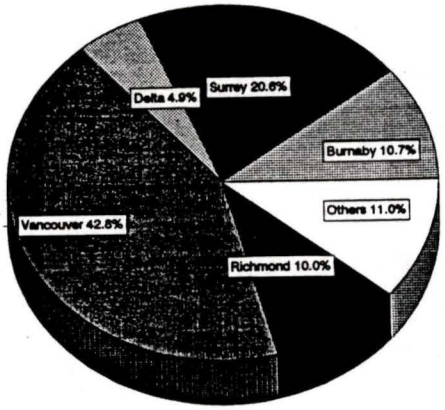


Figure 3.1 Greater Vancouver

11,130 South Asian Fijians live in the Greater Vancouver-Lower Mainland area of British Columbia with the majority living in the city of Vancouver (Figure 3.2). The majority of South Asian Fijian newcomers to the Greater Vancouver area are recent immigrants, but some are internal migrants from other areas of Canada (ISS, 1993).

FIGURE 3.2

MAJOR CONCENTRATIONS OF SOUTH ASIAN FIJIANS LIVING IN THE STUDY AREA



Source: Settlement in the 1990s, ISS, 1993: 198.

Based on 1991 Census data, fourteen percent of the total South Asian Fijian community (1,575) were newcomers who arrived in Canada between 1988 and 1991 (ISS, 1993). The majority of the South Asian Fijian population is between the ages of 26-65 (ISS, 1993: 199) with women comprising 52% of

this population (Table 3.1).

TABLE 3.1

DEMOGRAPHIC CHARACTERISTICS (1991) OF SOUTH ASIAN FIJIANS LIVING IN THE STUDY AREA

SEX	Female	5740	52%
	Male	5390	48%
AGE	Children (0-12)	315	3%
	Teens (13-18)	620	6%
	Young Adults (12-25)	1590	14%
	Adult (26-65)	8020	72%
	Seniors (65+)	550	5%

Source: ISS, 1993: 199.

3.3 Sampling

The sample was drawn from urban areas of Greater Vancouver given that most South Asian Fijians are concentrated in urban areas due to existing support networks and available employment (Buchignani, 1977).

Initially, only women who had lived outside of Fiji for fewer than ten years were targeted, in order to concentrate on the experiences of newer immigrants. However, the initial contacts had been in Canada much longer and it seemed counter-intuitive not to interview them simply because they had lived in Canada for a longer period of time. These women were

interested in the study and stated that many of their initial experiences in Canada had had a great impact upon them, and they were willing to share this.

It is also interesting to note that the duration of time that participants had lived in Canada seemed to roughly correspond with two major political events in Fiji, both of which spawned an increase in Fijian emigration to Canada and elsewhere. Consequently, the sample is conveniently divided into two groups: those being in Canada sixteen or more years, (corresponding roughly to Fiji's Independence from Great Britain in 1970), and ten years or less, (corresponding roughly to the military *coup* of 1987).

Three perspectives on the research topic were sought through the sampling process. These perspectives are provided, first, by service providers who work with South Asian Fijian women (n = 9) and, second, by individual South Asian Fijian women (n = 20). The third perspective was to be provided through focus group discussions with individual women. However, this stage of the research was not successful for a variety of reasons (section 3.4). Although this third perspective was unsuccessful, the previous two perspectives satisfy the triangulation necessary for enhancing the validity of qualitative data collection (Denzin, 1994; Janesick, 1994).

The sample was distributed across five municipalities in Greater Vancouver (Table 3.2) and closely reflects population concentrations of South Asian Fijians in the Lower

Mainland (Figure 3.2).

TABLE 3.2
DISTRIBUTION OF SAMPLE IN
GREATER VANCOUVER/LOWER MAINLAND

	Service Providers	Individual Women
Vancouver	6	8
Burnaby	2	4
Surrey	1	3
Richmond	-	3
Coquitlam	-	2
TOTALS	**9**	**20**

Service providers having regular contact with South Asian Fijian women were identified through community, support, and health institutions such as Orientation Adjustment Services for Immigrants Society (OASIS), MOSAIC, Surrey Delta Immigrant Services Society (SDISS), The Immigrant Services Society of British Columbia (ISS), Immigrant and Visible Minority Women of British Columbia (IVMWBC), and municipal health departments. In many cases these service providers had direct contact with South Asian Fijian women, either through provision of counselling services, other support services or through their own social networks. Service providers were extremely helpful in outlining the goals and objectives of the

research to potential participants, thus facilitating entry into the South Asian Fijian women's community. Through this referral process potential participants gave preliminary approval for the researcher to contact them and arrange an interview. It was through this networking or snowball sampling method that individual participants were identified.

All nine service providers were women of colour. Of these, 78% were of South Asian origin but were not from Fiji. Further, with one exception, all had emigrated to Canada within the past thirty years. This enabled service providers to expand upon their professional experiences with personal anecdotes about their own experiences as immigrant women and, in some cases, remark on changes over time.

Twenty individual South Asian Fijian women between the ages of twenty-one and eighty-four were interviewed. The median age of the sample was forty-seven years. The length of time the women had lived in Canada varied from under one year to twenty-nine years with ten of twenty participants having lived in Canada ten years or less. Two participants had been in Canada less than one year at the time of the interview.

All of the women were born in Fiji and had lived a considerable portion of their lives there. Most had been educated in Fiji and could speak English well, except for six participants over the age of sixty. While the older women could speak a little English an interpreter was present for these interviews which were conducted in Fiji Hindi.

Nine participants were employed outside the home while two were awaiting decisions on their immigration status and had not yet been granted work permits. Six women over the age of sixty were close to retirement age in the western sense, but continued an active household work role in addition to volunteering at the Hindu temple, caring for grandchildren and other younger relatives, cooking, and cleaning for the household. Two of these women maintained their own apartments, but visited their families on a daily basis.

Seven participants were born in Suva, Fiji, the capital and largest city in Fiji with a population of about 85,000 (Bryant-Tokalau, 1994). Suva offers the most complete range of health services: health centres, private doctors, as well as the main hospital (Colonial War Memorial). Thirteen participants were born in or near much smaller communities of just a few thousand people such as Nausori, Tailevu, Navua and Raki Raki. Health care facilities are much different in these towns, although Navua does have a small hospital. Most other small towns and villages have a health centre with staff nurse(s) and perhaps a few doctors.

The sample represents a wide range of socioeconomic backgrounds, education levels, ages, marital statuses and geographic origins (rural/urban hometown in Fiji). This sample diversity is most likely due to the diverse referral sources used in compiling this snowball sample.

3.4 Data Collection

A checklist of topics was designed to complement and facilitate an unstructured depth interview process (Appendix A). The checklist, informed by the literature as well as the researcher's experience in Fiji, was divided into two sections. The first contained questions which facilitated the collection of demographic information (age, marital status etc.). The second section encouraged women to talk about a variety of health concerns and experiences, including their definitions of health, use of health services, general state of health, family care, language issues, transportation, new cultural experiences, employment, and other concerns.

The checklist of topics, an information sheet about the study (Appendix B), and a letter of informed consent (Appendix C) were made available in both Hindi and English and were explained prior to beginning the interview. The interpreter read the research information aloud in Hindi to those who could read neither English nor Hindi. Two individual women and three service providers requested that information about the study and the checklist of topics be mailed to them prior to the interview.

Interviews commenced June 28, 1994, and were completed by September 30, 1994. Interviews with service providers averaged one and one half hours in length while those with individual women averaged fifty minutes in length.

The researcher directed the discussion, which mimicked a

conversational style, by ensuring that all topics were covered but in no particular order. Typically, all topics were covered in the course of the conversation with little guidance from the researcher.

Social science research, particularly in ethnographic, feminist, and interpretive traditions, necessitates reflection upon the role of the researcher in a research project (Denzin, 1989, 1992; Bonnett, 1993; Dyck, 1993; McDowell, 1993; England, 1994; Nast et al, 1994). All researchers are in essence outsiders in relation to those they are engaging in research with.

In this research, the researcher was aware of being an outsider in several respects. First, the researcher was a white woman. Second, the researcher had a relatively high level of education. Third, the researcher was born and raised in Canada, a country perceived to have one of the highest standards of living in the world - a country that is very "developed" in the economic sense. To women from Fiji, which is defined as a "developing" country, there are obvious differences on the basis of ethnicity and economics. More implicitly, there are the differences based on the history of British rule in Fiji - the colonial legacy. Dyck (1993: 55) explains that gender is an insufficient criterion on which to base insider status:

> Thus while women researchers and subjects as gendered subjects are expected to have commonalities in experiences, there are also significant divisions which do not admit one as an insider on the basis of being a woman alone, and require the researcher to examine her own relationship to the research and the potential use of the information gained.

In most instances interviews entailed two women having a conversation about important issues. Initial discussions with service providers as to the practical goals of the research, and the desire of the researcher to provide an outlet for the voices of South Asian Fijian women, provided some opportunities to work through the insider - outsider issue. The exception to this was an exchange between the researcher and a South Asian Fijian service provider who declined to participate in the study due to the "colonial legacy" surrounding the lives of South Asian Fijian women.

The researcher had been warned that male heads of households might be suspicious of the research and was prepared to interview women outside of the home if necessary (most women chose home as the interview venue - all were given a choice as to location). Interviews outside the home occurred with about one third of the individual women and were usually a matter of convenience to the researcher and participant due to noise and privacy, rather than secrecy.

Interviews were tape recorded, but in two instances detailed notes were also taken to supplement tape recordings

due to external environmental factors such as noise. Notes were written up in detail immediately following these interviews. In some interviews children were present, or there were interruptions such as telephone calls. In two cases, participants received visitors during the interviews who then waited until the interview was completed so that they could then participate. While uniform interview environments with no interruptions would be ideal, the everyday life activities of the participants could not be placed "on hold" in all cases. Participants appeared to want to continue the interview regardless of interruptions, although the true impact of the interruptions is not known. The interruptions did not appear to affect the interview account upon later analysis.

In order to ensure confidentiality for the purposes of this thesis, participant's names have been changed in the text. All interview tapes, documents and transcriptions were destroyed at the conclusion of the research period, as per the agreement with participants.

Focus group interviews or exploratory group sessions are a qualitative research technique frequently utilized in social science research (Hedges, 1985). A focus group meeting is a discussion in which a small group of six to twelve participants, guided by a facilitator, talk freely and spontaneously about salient themes around a particular topic.

It was initially proposed that focus group discussions

would be employed in this research to supplement the information provided in individual interviews on community knowledge, beliefs, attitudes and perceptions about health and health care. Focus groups would have provided the third element in a triangulation of methods, the first being service provider interviews, and the second being interviews with individual women.

Attempting to set up focus groups with the participants in this research proved difficult for two reasons. First, individual women were reluctant to participate. Second, an attempt to utilize meeting space designed specifically to serve the needs of South Asian women failed when the researcher was confronted with being a "white, outsider". These factors contributed to the abandonment of setting up focus group discussions with the South Asian Fijian women.

Most of the women the researcher met with individually seemed unwilling to meet and/or discuss their health concerns in a group setting. Reasons for this included: feeling shy, fear of relatives and friends finding out about problems, gossiping, and lack of transportation. It is uncommon for South Asian Fijian women to discuss intimate or serious problems outside of the family setting, although according to service providers more women are seeking assistance from community agencies. Also, some women may have had trouble arranging transportation to such a meeting, as they rely upon relatives for transportation.

When attempting to find appropriate space for the focus groups, the researcher was unable to use the South Asian Women's Centre (SAWC). Reasons provided in a telephone conversation with a member of the SAWC Board included: (1) the ethnicity of the researcher (a white woman), and (2) the fact that the Board did not support "outsider" research projects. This response was disappointing, especially since written application to the Board had been made with an offer to discuss the research and its implications in detail. The response was not surprising, however, considering current attempts by "oppressed" or minority groups to gain control over their own activities and to encourage empowerment from within.

Because the research was participant-driven, attempts to set up focus groups were abandoned. Fortunately, the success and depth of the individual interviews with service providers and South Asian Fijian women provide a rich base from which to explore health in place.

3.5 Methods of Analysis

The goal of the interpretive process, which includes reading, coding, sorting and major themes analysis, is to illuminate the world of lived experience of the research participants (Denzin, 1989). In order to do this, a systematic, organized process is necessary.

3.5.1 Transcription

All taped interviews were transcribed verbatim and ranged in length from one-half to two hours. The transcripts are the basis of the analysis for this thesis.

3.5.2 Coding and Major Themes Analysis

The analytical approach was primarily inductive; that is, the knowledge gained through the processes of reading, coding and sorting the transcripts was used to interpret the major themes emerging from the interviews.

The reading, coding, sorting and major themes analysis was a simultaneous process which necessitated an organized set of files containing information emergent at various stages. Segments of interview text were coded in the margin and body of the transcript using a set of codes and subcode abbreviations which emerged from both the checklist of topics, and the transcripts themselves (Table 3.3).

Part of the analytical process was less inductive because some of the topics on the interview checklist were included in order to elicit specific responses (*a priori* themes). For example, topics decided upon before research commenced such as physical health concerns or health services used most often, were mentioned during the course of the interviews and required an initial coding for frequency rather than interpretation for the purposes of subjective meaning. The relationship and meaning of the *a priori* themes to the subsequent emergence of less obvious themes is explored in the

TABLE 3.3
CODES AND SUBCODES USED IN ANALYSIS

Code	Abbreviation
Definition/Meaning of Health - General	**D**
Definition/Meaning of Health - Overt	**D/O**
Definition/Meaning of Health - Embedded	**D/E**
Health Knowledge	**KNOW**
Physical Health Concern(s) - General	**P**
Physical Health Concern - Chronic	**P/C**
Physical Health Concern - Acute	**P/A**
Physical Health Concern - Relational (e.g. diet)	**P/R**
Physical Health Concern - Temporary	**P/T**
Physical Health Concern - Result of Imm.	**P/Imm**
Physical Health Concern - Age	**P/Age**
Physical Health Concern - Lifestyle	**P/LStyle**
Emotional Health Concern(s) - General	***M**
Emotional Health Concern - Relational	***M/R**
Emotional Health Concern - Stress	***M/Stress**
Emotional Health Concern - Abuse	***M/Abuse**
Emotional Health Concern - Loneliness	***M/L**
Emotional Health Concern - Homesickness	***M/Home**
Emotional Health Concern - Age	***M/Age**
Experiences with Health Services	**HS**
Health Care System Use - Positive	**SYSTEM +**
Health Care System Use - Negative	**SYSTEM -**
Women's Roles in General	**WR**
Women's Roles in Health Provision	**HP**
Women's Roles in Child Care	**Child/C**
Women's Roles Changing	**RC**
Women's Roles Changing: Impact on marriage	**R/Mar**
Women's Roles Changing: Impact on children	**R/Child**
Role Reversals in Family and Community	**RRev**
Related to Social Networks	**Social**
Health and Moving	**HM**
Health/Health Care System in Fiji	**HF**
Health and Home	**H/Home**
Health and Work	**Work**
Space or Place Reference	**S or P**
Policy Suggestions	**POL-S**
Cross Cultural Issue	**X-Cult**
Language	**LANG**
Transportation	**TRANS**

* Codes under emotional health use an "m" as earlier in the coding process this category was labelled "mental" health. This was later changed to "emotional", although codes in the transcripts were not altered.

later stages of analysis and discussion. Due to small sample sizes, *a priori* themes proved more relevant when related to the entire context of the results, rather than in and of themselves.

For the more inductive major themes analysis, some codes, such as "Definitions/Meanings of Health", remained unchanged, while others, such as "Cross Cultural Issues" evolved throughout the analysis process. Coding segments of transcript text enabled the researcher to collect the interview segments on a particular topic, to note relationships between interview segments and to present the results as those themes which repeatedly arose, on their own, but also in relation to other themes and which seemed most important to the participants.

Information on age, duration of time in Canada, and subset characteristics (service provider or individual woman) informed the sorting and major themes analysis as well. For example, the researcher was able to collect several interview segments referring specifically to the experience of loneliness and depression in older women, from both service providers and individual women. These particular coded segments also linked to or were discussed by women in the context of language barriers. As more coded segments became available on certain topics, certain links became more firmly established. For example, eventually all the coded segments on loneliness in older women were collected in one file.

These segments in turn, eventually contributed to the major theme of emotional well-being, with age, language and role changes having a strong influence, and linking with other major themes.

When looking for meaning in the responses, again using "Definitions/Meanings of Health" as an example, the analysis involved an awareness of different types of meaning. Not only were meanings of health expressed in response to the specific topic on the checklist in an overt way, they were expressed in different ways throughout the interviews in relation to feelings and experiences of the women. Consequently, the code "Definitions/Meanings of Health" has subcodes, such as "Overt" and "Embedded" to address different types of meaning. An example would be the woman who described health as "everything" to her in the context of the excellent care she received in the hospital. While this seems like an overt response or definition, there are other meanings embedded in her use of the word "everything" to describe her health experience.

Topics seldom mentioned, avoided, or which elicited unrealistic responses, such as "never" or "always" were also found to be important. For example, one individual woman indicated that abuse "never" occurred in the South Asian Fijian community, in Fiji or Canada, but that it was very common among Punjabis. Such a response differed greatly from the general comments of other women on this sensitive topic.

For example, many women acknowledged the problem in their 'community', but were fortunate not to experience abuse themselves. Or, many who were experiencing abuse (or had experienced it) acknowledged it, or even raised the subject. Such one-sided responses as "never" or "all" may underline the sensitivity of issues such as abuse.

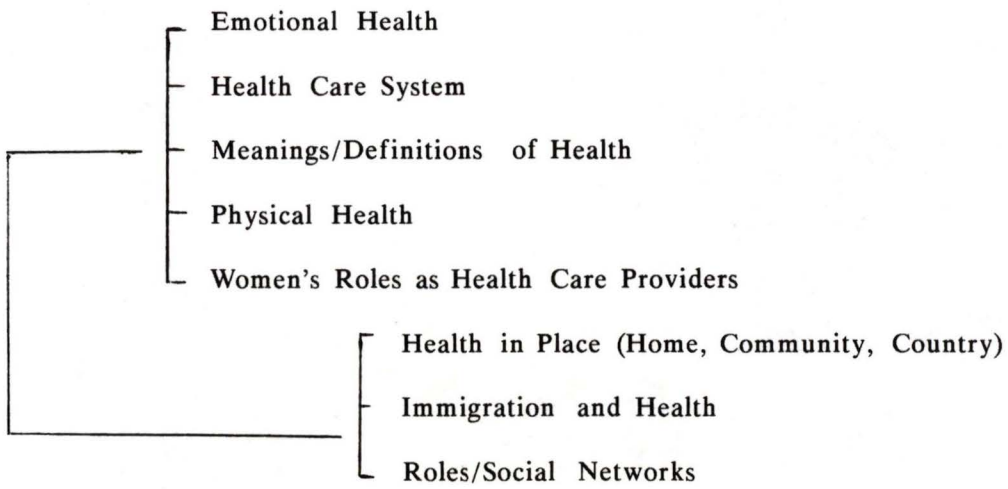
Codes also reflect the purposes and objectives of the study. A good example is the "Policy Suggestion" code. This enabled a summary of policy suggestions to be presented in the conclusion to this research (section 5.4).

After an initial reading and coding of transcripts, coded documents were re-read and coded in more detail as necessary. Coded segments were then sorted into larger groups of segments according to theme. Quotations from the interview transcripts were selected to illustrate the major themes in the text.

In the final analysis, the dominant relationships between coded segments were found to link physical and emotional well-being, and women's changing roles in the family upon migration to women's views of their health concerns (Table 3.4). These themes link to one another as they apply to individual women's experiences and to the larger context of family, community and country).

TABLE 3.4

MAJOR THEMES



3.6 Summary

The objectives of this research were threefold. First, to document the health concerns of South Asian Fijian women; second, to investigate the links between perceived health status and participants' perceptions of the immigration experience; and third, to investigate links between ethnicity and health in place for this immigrant group. Implicit across these objectives is the uncovering of meaning in social life in relation to changing definitions of health and evolving theoretical approaches in health geography.

The study area of Greater Vancouver was chosen due to recent increases in South Asian Fijian migration to the area.

Approximately twelve thousand South Asian Fijians currently live in Vancouver (ISS, 1993); fifty-two percent of these are women. In addition, the researcher lived in Fiji for three years and was familiar with the historical and social context surrounding this migration.

The sample was selected on the basis of two criteria. The first goal was to identify service providers that work with South Asian Fijian women in health and social services (n=9). The second was to identify individual South Asian Fijian women willing to participate in the study (n=20). The networking (snowball) process of sampling was employed in order to identify willing participants.

Depth interviews, using a checklist of topics as a guide, were used to explore the ways immigrant women define and approach health concerns in order to reconstruct these experiences in the context of their everyday lives. All taped interviews were transcribed verbatim for analysis using a primarily inductive approach. A rigourous and systematic reading and coding of the transcripts was used to guide interpretation of major themes. Major themes were also related to the study objectives and the model, "Contexts of Health Care Knowledge" to see if links exist which substantiate research objectives and the theoretical perspective - the social construction of health in place. Quotations from the interview transcripts were selected to illustrate the major themes in the text.

Chapter Four presents profiles of individual women in order to provide context for the discussion of the major themes in Chapter Five. These profiles provide a link between women's everyday life experiences and their achievement of health in place, and inform the theoretical view of health as a social construct.

CHAPTER FOUR: WOMEN'S EVERYDAY LIVES IN CONTEXT

This chapter contains profiles of individual women's lives. This biographical narrative approach has been used in medical anthropology (Kleinman, 1986) and health geography (Dyck, 1995). The overall purpose of the profiles is to link the conceptual framework guiding the research with women's life experiences as the context for their experiences of health in place (Section 2.3). The profiles are based on themes involving family and social networks, the work that women do, and cultural change, all of which influence or shape the context in which women live out their everyday lives. These themes emerged from the data collection process (Section 3.4) as well as the literature (Sections 2.2 - 2.4). Individual profiles have been chosen for two reasons. First, they represent the range of women's experiences in the study, and, second, their everyday life experiences provide the substantive link to health in place, thus informing a social constructionist approach. The profiles are valuable in providing context for the experiences and everyday lives of the women in this case study, but are not generalizable. Further, due to the small sample size and the importance of maintaining confidentiality and anonymity, each profile mirrors not one woman's life but a composite of shared experiences.

4.1 Govinda

Govinda (age 40) migrated to Canada seeking a better life for her and her children, and while her youngest son (age 11) lives with her, two teenaged sons remain in Fiji with their father. Since their arrival in Vancouver less than one year ago, Govinda and her son have been sharing an apartment with Govinda's sister and her family, which is located close to public transit, a major shopping centre and medical services. Govinda divorced her husband in Fiji because he is a heavy drinker and both physically and verbally abused her since the birth of their youngest son. Govinda felt that she had to tell the researcher her reasons for leaving Fiji and two of her children, primarily because of the stigma attached to women who leave their families and children behind and migrate overseas. She misses her children terribly, but the stigma of being divorced and leaving her children was also something that she was seeking to overcome. She felt that if her two older sons could come to B.C., she would be less depressed, and would be able to stop worrying.

Govinda's long term goal is to sponsor her two older sons to emigrate. Her family network in Vancouver provided her with an initial place to live and a foundation upon which to build a new life. Although Govinda has the opportunity to socialize with her family friends and few relatives that live in the Vancouver area, she says that she

prefers to stay home. She misses Fiji, particularly the easy pace, climate and familiar places. She says that this makes her lonely and depressed sometimes. In addition, the move to Canada made her "depressed, because we don't know the places..." She prefers outings to the seaside or picnics over visiting in people's houses, for this she finds "boring." Govinda worries about her young son, describing his play environment in Fiji as open and healthy where no one bothered him - but when he plays outside here, there is always "complaining" either about the other children (older children teasing) or about not having toys such as a bicycle or skateboard. Also, she feels that her son does not respect her at times and she is critical of the way Canadian children "speak out to their elders". She feels this behaviour is having a negative influence on her son, and it is the source of arguments between the two of them. In addition, there is the concern that his father may come to Canada and try to contact him, or herself.

Govinda works part-time as a cleaner in a care home for older people. She is working outside the home for the first time in her life and finds the economic strain one of her greatest worries. Her continuous search for a full-time job to ease her sister's family's financial burden, and to save the money required to sponsor her sons, remains central to Govinda's short-term goals. She enjoys her work but commuting time is long and can be very tiring. She works

various shifts involving late night work or even overnight. She has difficulty arranging child care because she does not want to rely solely upon her sister's family.

Govinda feels she is coping well in spite of the initial adjustment to a new country. She feels that all the worries and concerns associated with migrating affect a person's health, especially if that person cannot find a job. In general she thinks of herself as quite healthy, but suffers in the winter due to the cold weather. She considers the health care system in B.C. as good, but too expensive (she pays $64 per month for herself and her son). She also would like to see job training provided to all immigrants, so that finding a job is easier and has less of an impact on a person's health. But she is optimistic about her future. She wants to save the money necessary to sponsor her older sons and to find her own house to live in. She feels burdened by these financial worries and at times longs to be in Fiji: "it was just nice and easy, everything. . . there was less money, but good...we had better living I think."

4.2 Kirmina

Kirmina (age 21) is a single mother who has lived in Vancouver for about a year. At the time of the interview, she was living in a house in Vancouver which was not too far from shopping, public transit and medical facilities.

Kirmina's ex-husband is a South Asian Fijian who has lived in Vancouver for several years. He and Kirmina had an arranged marriage in Fiji and they lived there for a short time together before he returned to Vancouver to begin the sponsorship process. Kirmina arrived in Vancouver eight months later to find that her husband had not initiated the paperwork necessary for her to immigrate. He had decided that he did not want to live with her, and wanted a divorce. Within a month, Kirmina gave birth to a daughter in a local hospital, and at the time of the interview was living with South Asian Fijian friends, acquaintances of Kirmina's father's brother (who still lives in Fiji), who had taken her in only because of distant contact with her family. At the time, Kirmina had no official status in Canada, given that her tourist visa had expired. She was thinking of filing a refugee claim, but did not want to chance being returned to Fiji. Kirmina was fortunate to have a limited social network through her uncle's acquaintances which provided the only means of support for her and the baby. Yet her social ties were threatened: not only did she not have a strong support system in Vancouver, it was possible that her support system in Fiji was threatened by the stigma of her divorce. She speaks to her parents in Fiji on the telephone once in a while, but fears returning to Fiji because of the stigma of being a "rejected" wife. This set of related worries contributed to her feelings of rejection,

isolation, homesickness and depression.

Kirmina was not employed outside the home. She said that her husband's family had treated her badly, denying her money and the opportunity to go out - they had treated her like a "nothing." She once had dreams of becoming a nurse, so that she could help people, but had only completed education to Form Four (Canadian equivalent of grade nine). The possibility of nurse's training would be a long way off. She came from a small town and although she had been to school was not very confident about speaking English which curtailed her activities in Canada, as for example, in being reticent about using the telephone. Consequently, she spent a lot of time at home alone with her baby and had not even taken the baby for a check-up since its birth. In spite of this, Kirmina obviously experienced a lot of joy in caring for her baby and enjoyed her role as a mother. She did acknowledge that she needs assistance to perform this role and was seeking help from a support agency in Vancouver.

As Kirmina has only been in Vancouver for a short time, she did not know the city well, and had not learned how to navigate public transit. Although she did not leave the house very often, she was completely dependent upon others to drive her places. The combination of events leading to and comprising Kirmina's everyday life situation has a direct impact on her ability to achieve (emotional) well-being and use the health care system effectively. Kirmina

is very sad about her situation, and although she appears to be physically fit she is experiencing feelings of helplessness, homesickness and depression. However, in the face of these disadvantages, on a day to day basis, Kirmina is coping as best she can.

4.3 Verinder

Verinder (age 46) is married and has two children. She immigrated from Suva, the largest city in Fiji, 22 years ago, in order to join family members in Canada, and to begin her married life. She lives in a four bedroom home in a residential neighbourhood in Surrey, close to public transit, shopping, medical facilities and family members. She has her own car which she uses on a daily basis. She has an active social network in the Vancouver area, and is a member of a South Asian cultural association. She is also active in parents' groups and enjoys attending the sports activities of her two sons, ages thirteen and sixteen.

Verinder has attained a university education, and was taking night classes at the time of the interview. She is a professional and employed full-time. She said that when she had been experiencing stress in her life several years ago, she sought refuge in education and immersed herself in her children and social network. She is comfortable economically, but only because she and her husband work full-time.

During the interview Verinder reported that her health was good although she was entering menopause and was concerned about breast cancer. While Verinder describes herself as a very strong and capable woman, she has experienced many years of verbal and physical abuse from her husband, whom she described as an alcoholic. She discussed her marriage in the context of women's health. She and her husband were separated for a time, but pressure to "save face" in the South Asian Fijian community convinced Verinder to try again with her husband. She describes her battle as ongoing, and that she had to constrain herself in the home just to keep the peace. Verinder does not consider herself alone in such a struggle for she believes there are many South Asian Fijian women in a similar position, but who do not readily talk about it. Verinder described herself as strong enough to cope, but worried about the effects that abuse has on the health of her South Asian Fijian peers. She stated that those who denied that abuse occurred in the South Asian Fijian community were "turning a blind eye."

Verinder's social network was extensive and reached beyond her family and extended family to colleagues and acquaintances from work. Verinder loves to cook and describes her family and social relationships as being intimately linked to the preparation of food and the gathering of everyone to eat it. Verinder also considers a balanced diet important to the maintenance of good health.

At the time of the interview, she had recently attended a family reunion where she and her siblings visited for a week. She described in detail the fabulous feasts they prepared and how they enjoyed being in one another's company.

Overall, Verinder's everyday life consists of her full-time job, her night classes at community college, the caring of two children, the careful balancing of her relationship with her husband, and her social commitments.

4.4 Mrs. Gopal

Mrs. Gopal (age 59) lives in a large, comfortable house in Burnaby with her husband, a daughter, and two sons, their wives and their children. She has lived in B.C. for 21 years and while her home is in close proximity to many amenities, her husband or sons drive her wherever she needs to go. Mrs. Gopal's life revolves around her family. She goes out shopping and for outings and visiting with family members, but is most content to stay at home and run her large household. Her social network is bounded by family, extended family and close friends from Fiji. The Gopals rarely socialize outside of this network. Mrs. Gopal speaks English fairly well, but says that she does not use it very often, as most of the people she interacts with are fellow Fijians - even her doctor, a Punjabi, speaks Hindi.

Mrs. Gopal's conception of health is firmly rooted in

her concern for the health of her husband and family. Mrs. Gopal loves caring for her grandchildren and says that she misses them even when apart from them for a short time. Mrs. Gopal's daughters live close by, and often, especially on long weekends, the family gathers at the Gopal home to have a lot of "fun." Mrs. Gopal's husband travels to Fiji at least once a year and spends several months there. He is still very attached to Fiji and wishes to maintain contact with his friends and family that still live there. Mrs. Gopal says that her husband would probably go back to Fiji to live now, if she were agreeable. Yet she refuses to leave her family. Even though they encourage her to go back for a visit, or even to retire there, she says that her family means everything to her and that Fiji would mean very little without them. She also finds the cooler climate in B.C. more comfortable than Fiji's heat and humidity.

At present, Mrs. Gopal works full-time in her home, caring for her grandchildren and the rest of her family. She does not get tired now, nor has she ever, of being at home, even when her children were younger and she and her husband ran their own cleaning business (subsequently taken over by their sons). She used to care for her children all day, and then clean buildings in the evening. Mrs. Gopal says that many of their friends from Fiji became successful by working very hard, with all of the family contributing. This meant working long hours cleaning after spending all

day caring for children, cooking and maintaining the home. She felt that sometimes her family took her care for granted, but felt that it was her duty to provide for them, and that ultimately they did appreciate her efforts.

Mrs. Gopal says she has always been healthy, probably because God made her strong so that she could care for her entire family. Two of Mrs. Gopal's daughters-in-law live with her, and do help around the house when they can, but they are working full-time outside the home. Mrs. Gopal's daughters are not employed because of the financial security provided by their husbands' employment, "which is nice." Mrs. Gopal is not rushing the one daughter living at home into marriage. She feels that she would rather her daughter find just the "right boy", because if not, then "there can be problems." She hopes that her daughter can marry someone from Fiji, but will not necessarily insist on arranging her daughter's marriage, because her daughter is also a "Canadian girl".

Mrs. Gopal's husband is the head of the household something she does not always overtly challenge. For example, prior to the interview with Mrs. Gopal, Mr. Gopal provided some insight into how Muslim families live, the type of food that they eat and their basic philosophy of life. In addition to the researcher, another woman (who had been canvassing the neighbourhood distributing restaurant advertising) was invited into the house for this part of the

visit. Mr. Gopal's treatise on diet was related to the fact that, being Muslim, he and his family did not eat at restaurants, and he wished to explain this to the canvasser. He is very proud of his family and their achievements in Canada which Mrs. Gopal mirrors in her attitudes toward people outside her social network; that is, kind and caring, but still aloof. The focus of Mrs. Gopal's life as well as her health concerns is her husband and family. And, although not the head of the household, she sees herself as very strong, playing a central role in caring for "all of them."

4.5 Mrs. Bajpai

Mrs. Bajpai (age 84) is from a small town in Fiji and has lived in Richmond, south of Vancouver, for eight years. She is widowed and lives in her own apartment which is on a bus route and close to friends and family whom she often visits.

Mrs. Bajpai does not work outside the home, but works at home for her friends and family. She emphasized that she now had more friends than family. Her everyday life consists of visiting with friends, caring for sick friends when necessary, shopping for daily living items such as fresh vegetables, and looking after her grandchildren occasionally. Mrs. Bajpai speaks very little English, but enough to manoeuvre within the Vancouver area without

feeling isolated. Mrs. Bajpai came to B.C. to live with her family after the death of her husband. They had been making visits to Canada for the past 24 years, but Mrs. Bajpai decided that when she was widowed, her best place was with her children in Canada. She has family in Fiji and Australia, which she misses, and said that her "stomach burns" and her "back burns" because she misses them so much. This is a South Asian Fijian expression related to health that means you are never quite content because you miss the family members who are not with you; some in front, some behind.

Mrs. Bajpai is aware of tundroosti (Section 5.1) and considers food and diet as primary determinants of health. She thinks that a balanced life fosters good health. Mrs. Bajpai says that in B.C. you have to do what the doctor says to stay healthy, whereas in Fiji you can use "jungle medicine" if you want to, that is, medicinal plants and herbs. Mrs. Bajpai is independent, and often takes the bus to go shopping with her friends, other older South Asian Fijian women. Her son and daughter-in-law have taken on the responsibility of driving her places now that she is getting older, but tension arises when they expect her to shape her social schedule around theirs so that they are not inconvenienced. For example, during the interview her daughter-in-law came unexpectedly to pick her up and there was quite a bit of tension between them. Eventually, the

daughter-in-law left, and the interpreter told the researcher that Mrs. Bajpai had done what she wanted and refused to go. She was annoyed that her family expected her to just "up and leave" at their bidding.

She feels that most people are "okay" when they come to Canada, as long as they have some family here to help them out. She says that she misses Fiji, still, and that probably everyone who leaves there, does. Mrs. Bajpai thought that the major thing causing illness in older people coming to B.C. was the fact that they had to remain indoors all the time, cut off from their friends and family. This is partly due to climate, but also due to living in a big city, not necessarily close to friends and relatives. She said "who can you tell your troubles to - because they eventually come out in the body." When asked what would help, Mrs. Bajpai stated that sharing information was a good thing - as was occuring in the interview exchange. Mrs. Bajpai was fairly happy herself, and had had what she describes as a good life.

Mrs. Bajpai's independent spirit and her desire to help others contributes to her overall well-being. She said that since coming to Canada, she has learned how to take care of herself by observing the problems of others, and by helping her friends whenever she can.

4.6 Summary

The everyday lives of the women profiled above reflect both their life and their experience of place. While not generalizable, the profiles are illustrative of the everyday lives of the women in this study, especially in relation to social networks, the work that women do, and cultural change.

For example, Kirmina's place in the world and her connections in social networks (as defined by her roles) have changed fundamentally since she married and left Fiji. No longer either a dependent daughter or wife, she is renegotiating her place dependent upon her experiences in Vancouver. She is redefining herself in terms of social, cultural and economic constraints. Being rejected as a wife signifies a major social failure on the part of a woman in South Asian Fijian culture. There is a similar stigma attached to "rejected" wives as there is for women who are divorced, leave their families or otherwise breach social norms. This failure is not reflected on the woman alone, but on her entire family. Kirmina is not alone among participants in fearing the effect her husband's rejection of her (or a divorce) was having on her entire family in Fiji. Consequently, Kirmina's social network is compromised, she is unable to work outside of the home to support herself, and she is having difficulty coping with cultural change. As a result, Kirmina was constrained in

using the health care system effectively. The researcher assisted Kirmina in using the telephone to contact the health unit in Vancouver regarding immunizations for the baby for Kirmina was determined to have this done. In contrast, Mrs. Gopal carried her conception of "home" with her to Canada because she sees her home, family and social network as inseparable. Though she misses Fiji, her role in the family has provided the means for her to define herself and to achieve a healthy outlook on life. Verinder is an exception with regard to her social networks. Most participants' social networks are family oriented but Verinder's extends beyond her family to include acquaintances from work and college, which she finds very satisfying.

The work that women do, whether inside or outside the home, focuses on their husbands and families. For example, Mrs. Gopal works in the home and looks after her family on a daily basis. Verinder and Govinda work both inside and outside the home primarily for economic reasons. Verinder's career also contributes to her personal fulfillment. Verinder is an exception in regard to the work she does and the level of education that she has attained, as most of the other women in the study who were employed outside the home worked in the cleaning, service, or clerical sectors. Without exception the women see their families as the central beneficiaries of their labour. While social

networks and the ability to perform work inside or outside of the home which is satisfying are important to the ability of women to achieve health, they do not guarantee a trouble-free life. For example, Verinder may appear to have many advantages, yet her well-being is challenged on a daily basis in coping with an abusive husband.

With regard to cultural change, some women, such as Govinda, are concerned with their children losing their "Indianness" and becoming too outspoken like "Canadian" children. Govinda is attempting to maintain authority over her son, while facing economic constraints, a demanding part-time job, and the pressure surrounding her own familial role changes. Similarly, in order to maintain to some degree, the authority usually accorded older South Asian Fijian women, Mrs. Bajpai gives into her son and daughter-in-laws' plans only occasionally. By doing this, she is able to mitigate the impact that cultural change is having on her daily life as well as on her expectations of old age.

The major themes arising from the analysis are discussed in detail in Chapter Five. All themes are linked to, and inform one another, and no theme is exclusive of another. By discussing the themes separately the results could be presented in an orderly manner, but for the purposes of understanding, it is important to consider these themes together, and in the context of women's everyday lives.

CHAPTER FIVE: THE HEALTH CONCERNS OF SOUTH ASIAN FIJIAN WOMEN LIVING IN VANCOUVER, BRITISH COLUMBIA

This chapter presents the results of the research based on the major themes analysis from the depth interviews with South Asian Fijian women and service providers. Section 5.1 outlines what health means and how health is defined by the women in the study. Section 5.2 summarizes the health experiences of the participants under the themes of physical health, emotional health, the health care system, and women's roles as health care providers. Section 5.3 discusses the results in relation to the theoretical framework of this research. Related to this, the concept of "healthshock" (Bhayana, 1991) is used to assist in understanding women's abilities to achieve health in the new spaces created by migration.

5.1 The Meaning of Health: Beyond the Biomedical Model

Depth interviews opened with a discussion of the meaning of health. Perceptions of health, illness and disease are broad-based, and participants consider health a resource for everyday life, and as something intimately connected with one's daily life activities and one's ability to enjoy life, not simply the absence of disease.

The researcher introduced the term, tundroosti, which translates into English as well-being, and asked women to talk about what the term meant to them. According to many women

this term summarizes how health relates to everyday life.

The following quotes express individual conceptions of health and tundroosti. Indira (age 34) says that:

> It means your health, right. Sometimes it's good, sometimes it's bad and sometimes it's very worst...it means physical and, actually they say it's a physical health, right, but also feeling happy, mental - and sometimes we don't feel happy, right.

Mrs. Gopal (age 59) says that tundroosti means "good health, everything is a cha [okay]...husband's health is okay, the well-being...healthy...happy". Shamina (age 48) says that "Tundroost is healthy, yes, - swasta is Hindi, tundroost is Urdu. That word means healthy. It's a physical way more or less...the mind too, it's a collective word, you know, and it means everything...like health, it's a good health." Usha (age 40) describes tundroosti as

> healthy physically, but not only physically - I think you have to be healthy in your mind too - not just physically, but of course they both go together, naturally, if you are healthy in your mind you will be healthy physically.

Tundroosti was discussed by Gill (1988: 85) in her work on Indo-Fijian women's health strategies in Fiji. Gill (1988: 469) states that tundroosti encompasses the "Indian worldview, religious practices, and a holistic concern with the psychological and physical well-being." Tundroosti also "codifies Indian ideals (norms and values), and the social action necessary, given these beliefs, to maintain good

health" (Gill, 1988: 469).

Not all women spoke of health in terms of tundroosti, but similar ideas were expressed through references to cultural conceptions of health, illness and disease, or differences between eastern and western approaches to health. Verinder (age 46), who did not express health in terms of tundroosti and felt that most South Asian Fijians did not use the term in their vocabulary, stated that:

> Tundroost is health. We've never used that word because it's a Hindi word, it comes from the vocabulary of standard Hindi and we are used to the Fiji Hindi, which, and that word is not used very often. I know it because I have studied Hindi so it's not a familiar word in my vocabulary or I think, the vocabulary of people that I associate with.

Clearly, there are diverging opinions surrounding the concept of tundroosti and its linguistic origins. What seems clear is that the conceptions of health, illness and disease expressed by the participants are broader than those embodied by traditional western, curative medicine.

Cultural differences in the meaning of health are expressed by Susan, a service provider:

> I deal with women from all cultures. There are cultural differences in definitions of health. Some are physically and psychologically connected in their definitions. Some are purely physical in their definitions of health...There are distinct western and eastern differences in definitions of health. Socioeconomic status affects one's definitions of health as well. The more educated make more of a connection between mental and physical health.

Many women refer to the balance of hot and cold in the body. Although not many women could explain the origins of these ideas in relation to Ayervedic or traditional Indian medical practice in any detail, most related the concepts of hot and cold to balance and harmony in the body. For example, Surinder, a service provider born in India, states that:

> The meaning of health for most women is broad. It means a balance between the hot and cold. Imbalance leads to disease. Food restores or disturbs the balance. For example, during pregnancy women eat hot foods, or after the birth hot foods heal. Health for South Asian women is based on belief and healing relationships. There are many philosophies. In Canada, there are different expectations - health is different, how it is defined ... treatment, surgery. There is no one here to explain this to immigrant women.

Not all women believed in the concepts of hot and cold. Prem (age 52) said that her grandmother believed in these concepts, but when she herself was a new mother she ate cold food because it soothed her throat.

Women's definitions of health rarely referred only to one's physical state but rather to the balance between physical, emotional, and spiritual well-being. Sita (age 21) elaborates:

> I consider myself quite healthy. I consider health to be . . . not sick or not having an illness or some ailment. A balanced diet is important. Exercise is important. I think health is general well being.

These ideas about health extend into the everyday experiences of immigrant women. Vinita (age 51) states that:

> Health is how you feel; if you feel well enough to conduct daily business; some things may be preventing you from carrying on, such as the physical and the mental, things like worries, settling down, diet, what to teach your children - do you keep the traditional life skills or let them take part in [the] Canadian way of life. There is a big dilemma here.

It is important to note from the above examples that health is a far-reaching concept for these women which affects, and is affected by, virtually all aspects of women's lives. This realization provides a basis for further discussion of the health concerns of South Asian Fijian women in the context of health policy goals in the Province, which seek to broaden the definition of health and to formulate health policy that is culturally appropriate (B.C. Min. Health, 1993a). In addition, these examples assist in the explication of health geography - an approach which seeks to clarify the importance of one's place in the world and experience of place in relation to health (Kearns, 1993), and the possibilities for achieving health in everyday life (Dyck, 1992, 1993, 1995).

5.2 Health Concerns and Experiences

5.2.1 Physical Health

All persons seeking entry to Canada must undergo a complete physical examination. This examination takes place

in the country of origin and includes routine blood testing and chest x-ray to screen for tuberculosis. Applications from persons found to be suffering from communicable or infectious diseases are screened carefully by officials at the Federal government departments of Health and Employment and Immigration (Employment and Immigration Canada, 1995). Any applicant found to be suffering from a health problem that would provide an unnecessary burden on the Canadian health care system may be denied entry to Canada, but applications are considered on an individual basis under the close scrutiny and interpretation of experienced immigration officers (Employment and Immigration Canada, 1995). In the case of refugee claims made after a person is already in Canada, health screening is done in Canada by a licenced physician. Because of this health screening procedure most people coming to Canada from other countries are in reasonably good physical health. This does not preclude health problems occurring in Canada, however, and certainly does not rule out health issues related to the entire context of immigration, which often have a dramatic impact on overall well-being. Two women in this study reported that, due to the stress of the move to Canada, health problems occur in the first few months after arrival, often before the three month waiting period for Medical Services Plan (MSP) coverage in the Province of British Columbia has elapsed. One woman described how she injured her back while lifting furniture. Another said her family all

caught colds and 'flu due to the change in the weather. This results in extra costs incurred for medical services which may be difficult on the limited budgets of many new immigrants.

New arrivals in Canada are encouraged to apply for private health insurance coverage for the first three months in British Columbia but have to manage to cover both costs and arrangements on their own. Of all the women interviewed, none had done this, or were aware of this option.

Government sponsored refugees are eligible for free MSP coverage as well as emergency costs for refugee claimants for one time only (Multiculturalism B.C., 1994: 21). Refugee claimants must also get permission from the Immigration office if they need to go to the hospital, but the government will cover the costs if admission is warranted.

The physical health concerns of the women in this study fall into two general categories. The first category (Table 5.1), presents major health concerns expressed by health professionals and service providers. The second category (Table 5.2), presents major health concerns expressed by individual women.

Women described themselves as in good health, generally, even if there was some sort of chronic health condition that they were dealing with. They also appeared not to let their (or their families') physical health dominate their conceptions of being healthy. One service provider also referred to an inherent stoicism among the South Asian women

she works with; women tend to be quiet about their suffering.

TABLE 5.1

PHYSICAL HEALTH CONCERNS ACCORDING TO SERVICE PROVIDERS

Younger* Women	Older* Women
Reproduction:	Arthritis/Joint Pain
Anaemia	Nutrition:
Nutrition/Diet problems	Being overweight
Low birth weight babies	Diabetes:
Premature births	Diet related
Severe morning sickness	Inactivity
Stressful (western) birthing process	Social activities affecting diet
Conception difficulties	Cataracts/Eye Problems
Abortions among young girls	Fatigue
Fatigue	Back Problems
Work Related Problems/Injuries	High Blood Pressure
Back Problems	Lack of Exercise
Nutrition:	
Concerns with food availability	
Cost	
Preparation schedules	
Eye Problems: Thalacemia	
Lack of Exercise/Relaxation/Leisure Time	

* Terms "younger" and "older" were generally applied to the South Asian Fijian community at large by service providers, and do not refer to specific individual women in this study

According to service providers, the physical health concerns of women also depended upon their relative age. Reproductive issues were reported to be very important among younger women. Older women suffer more from diabetes and arthritis. Age-related health concerns are also common in the general population, however, and as Sonia, a health worker pointed out "there is very little research that has been done

on specific populations", so it is difficult to assess such problems in terms of cultural groups. She states that "there is a tendency to lump everyone who looks the same together; it doesn't matter if the people are fifth generation from China, or whether they arrived yesterday". She thinks that health status is related more to lifestyle, which is also related to culture, but is not entirely dependent upon it.

Service providers emphasized that many of these physical health concerns have a direct relationship to the social system affecting these women, which changes upon immigration. For example, a public health nurse noted that reproductive difficulties associated with poor diet such as low birth weight babies, are not due to food availability. The difficulty arises in the social situation of the women, their role in the family, whether or not they are working while pregnant, and if so at what times of the day (shift work), and other changes surrounding their daily lives. Uma, a public health nurse, elaborates:

> In terms of pregnancy a lot of them don't eat properly - here in B.C. and Vancouver we are seeing a lot of low birth weight babies being born to Indian women; not much study done but I would say that it is true. Diet . . . the breakdown of whole system that they grew up with. I really believe it is more of the social system; at home the practice when they are pregnant they take it easier, someone cooks for them immediately, looks after them, that whole thing goes on, with the first baby the woman goes back to her parents home so that she can be more comfortable and looked after.

The ability of the South Asian Fijian woman to cope with her diet and pregnancy effectively are dependent upon her position in the family, how traditional her upbringing has been, and the support that she receives when she arrives in Canada. Women are often beginning a marriage and entering an unfamiliar household and may not receive the level of caring and emotional support that they are used to.

Another major source of stress can be the birth experience in Canadian hospitals. Women may be used to giving birth at home, or in a small hospital setting with only nurses or midwives in attendance (although the Fiji government prides itself on a health policy which encourages the first, fifth and subsequent births take place in a hospital if at all possible). Strict cultural practices are followed after a birth in Fiji. These include drinking a beverage called sodh, a mixture made with milk, almonds, ginger and cardamom. This drink is intended to fortify the mother and the breast milk and is ideally provided in an atmosphere where quiet resting and being cared for by family members is common practice. The different pace, procedures and atmosphere in Canadian hospitals are often sources of concern to women from Fiji. One woman reported that many women she knows will take sodh with them to hospitals in Vancouver when they visit family members or friends who have given birth.

Kalbash, a service provider, sheds light on the pressure immigrant families are under economically and the pressure

this places on all family members, particularly women.

> Making roti. . . it is a task, and when you get here [B.C.] and you got the immigrant living a different time schedule - the husband go to work shifts and the wife going to work nights [at a] janitorial job and then she comes home to make breakfast ready for her children to go to school and her husband goes out to work, then she goes to sleep. So she is not free, not relaxed, she's not enjoying cooking because she has just spent a whole night working and cooking becomes a chore for her. Now in Fiji, she woke up, she was happily cooking fresh rotis for her husband and for anyone else whoever came, and it wasn't a chore but now it is. So those are the kinds of changes that - it's not a diet of what they're eating, it's how happily it's being prepared.

The preparation of food and the daily schedules of women change when women work outside of the home, sometimes at more than one job, and work full-time in the home, as well. This type of schedule leads to fatigue and contributes to the double, and even triple working burden of these women. Women may not eat well due to fatigue and emotional stain, and may no longer enjoy household tasks that seemed easier to carry out in Fiji.

Nutrition related health concerns such as diabetes and high blood pressure affect many older women. Again, service providers state that the social system is often responsible for problems with over-nutrition and diabetes in older women. For example, older women may be tied to the home caring for grandchildren and may not be as active as they should be for optimum health. They also do a lot of cooking in the home and

also in the community for special occasions. Overeating and lack of exercise predispose the body to adult onset diabetes. Uma, a public health nurse, elaborates:

> Diabetes is high in the older women. I would have to say more the older women than men, but definitely the older generation, period. We talked about how the women are tied to the home and raise the grandchildren, their extended family. . . you know the daughter-in-law goes to work and the grandma is looking after all the kids. So she's tied to the home and doesn't get to go out and burn calories from the food she eats. Whereas the older men, they like to go out for walks, they just go out and walk all day long and get that exercise. Secondly, wedding and party cooking in the culture. The women often get together and make the sweets for weddings. . . all that cooking and eating and tasting, it goes on, and they do it and then they bring some packages home because they went and helped somebody do it at somebody's house so they come home with lots of sweets. And I think that the whole way of that living is why we tend to see it more in the women than we do in the men.

High blood pressure is also related to a diet high in fat and salt. Uma reported that "just about every older [South Asian] person has hypertension." Other common problems for older women include arthritis, general aches and pains, and cataracts.

Other health concerns relate to women of all ages, but particularly working women. Work related injuries and back problems are common. Thalacemia and anemia also seem quite common among South Asian Fijians according to public health personnel.

One service provider also reported a higher incidence of "love marriages" (partner chosen by young people, not parents) among young South Asian Fijian women of eighteen or nineteen years of age. It should be noted, however, that arranged marriages are still common among South Asian Fijians and most do not end in divorce or separation. Not all young South Asian Fijian women choose their own mates. The service provider describes the young South Asian Fijian women that do, as more "carefree" or "modern" than girls from India where arranged marriages are even more common. They were more likely than women from India to have had abortions as teenagers, miscarriages at a younger age or to have had marital problems.

When individual women interviewed were asked about physical health concerns, they usually had little to say about specific illnesses or ailments (Table 5.2). When asked to describe her general state of health, Nazmeen (age 39) said:

> It's good, good. I don't have any medical problem. I just hurt my back a couple of weeks ago and I just started physiotherapy, but other than that I am fine.

Mrs. Gopal (age 59) has been in good health as long as she can remember:

> I go for check up. I am healthy because I have to take care of all of them! All the family - that's why god made me healthy.

Shamina (age 48) praised the health care system:

> Well, actually my health is very good. And in fact, I was sick for four months and the way the doctors looked after me, I think it was really marvellous. Otherwise I am fine. Yeah.

TABLE 5.2

PHYSICAL HEALTH CONCERNS ACCORDING TO INDIVIDUAL WOMEN (n=20)

Physical Health Concern	No. of women mentioning
Fatigue	11
Aches and Pains	8
Family Members' Health	7
Seasonal colds/influenza	6
Related to Reproductive System	4
Fear of Getting Breast Cancer	3
Related to cold weather	3
Hereditary Conditions (e.g. Rheumatoid Arthritis)	2
Asthma	2
Diabetes	2
No physical health concerns at all	2
Allergies	2
Borderline diabetes	1
Related to an accident	1

Vinita (age 51) relates good health to the ability to carry on her life:

> My health is good. God has given me the energy to carry on. There is so much happening. I am a busy woman!

Verinder (age 46) states: "I have a lot of energy and I don't know how to relax! I manage to do two thousand things at one time."

Fatigue is the most commonly reported physical health concern and is often mentioned in relation to the work that women do, both inside and outside the home. Indira (age 34) describes her job search as very tiring: "It's very tiring! I am looking for work in the factory because I have got some experience - in Toronto I was working in a factory". Govinda (age 40) talks about the work she does with elderly people in a nursing home:

> Well, you have to rush them [the patients], as I am saying, it's on your feet all the time, just like seven to eleven, if I work seven till eleven in the morning I have to be on running all morning. Very rushing, very good pay though. Very hard job. Sometimes you feel tired when you come home and you come from there, from Hastings to here, three buses and you get tired! I just sit down, have my shower, and just rest.

Service providers also frequently commented on the fatigue that women experience. Shirley, an employment counsellor stated that:

> Women often speak out about being depressed and tired. Women have actually said, "excuse me if I appear disinterested, but I am just so tired", or women were slumping down in their seats with fatigue or complaining of sore backs. This fatigue is connected with depression, overwork, you know two jobs plus home, or lack of a job or even fatigue connected with the job search.

The relatively low number of physical health concerns mentioned does not mean that physical health concerns are not important. Certain health concerns are of great importance to individual women and their families. Sita (age 21) states:

> My mother had rheumatoid arthritis and high blood pressure. She was age 52 when she died. I worry about the hereditary factor. I keep fit and work out and try to stay healthy.

Three women stated a concern with breast cancer. Verinder (age 46) summarizes her fears:

> I'm always worried that I've got breast cancer. I'm always going to the doctor. I had the mammogram but then after that I read that IT could lead to cancer - they [mammograms] could trigger, you know, if you did have a spot, if did have a lump it could trigger the lump to get bigger. Just the pressure of it. . . so I am concerned about breast cancer. It's strange. . .I am concerned about that. . . That's probably my only concern about my health, is breast cancer - you know you read so much and it's well my mother had a lump removed and it was caught at the right time.

Lifestyle health risks such as smoking and alcohol consumption were not common among the women interviewed. None of the women smoked, four drank alcohol occasionally, and one

was a moderate social drinker. But South Asian culture is not generally accepting of such practices for women as they contravene religious principles. Two women indicated that their families were less strict about alcohol consumption now that they were living in Canada and the women would consider having a glass of wine on a special occasion, for example.

In six cases, lifestyle health risks were mentioned in relation to the men in women's families. Some South Asian Fijian men drink and smoke heavily. This affects their health and also the well-being of their families. Eight women said they thought that alcohol abuse led to spousal abuse in both verbal and physical forms. This finding was corroborated by all service providers, although most service providers pointed out that alcohol abuse and spousal abuse happened across cultural groups. Four individual women stated that there were no such problems in their families, while three others, speaking for themselves and people they knew in the South Asian Fijian community, said it was very common, but remained hidden. Most service providers mentioned that alcohol abuse often occurred if men were unsuccessful in finding employment that utilized their qualifications and skills. One service provider, however, stated that this was yet another excuse for violence against women and children and blames culturally embedded ideas of male dominance as the reason for the abuse (see also section 5.2.2).

5.2.2 Emotional Health

It is problematic to discuss emotional health separately from physical health because the women interviewed do not see them separately. But, in order to emphasize the significance of emotional health to these women, they are presented separately.

All women interviewed mentioned stress or emotional upheaval as playing a role in their overall health. Women use various words to describe their emotional states. Depression is a word commonly used in the English language, and in western culture refers to a variety of conditions and emotions from feeling "blue" or "down" to clinical diagnoses of psychiatric disorders. The women interviewed in this study did not refer to clinical diagnoses or severe disorders when they used the word depression. Prem (age 52) uses the word to describe her feelings as a recent arrival in Canada:

> I was very depressed. I cried. I used to go up there in the bathroom and cry. It is very strange place, you don't know anybody. You can't talk to anybody in the street because people are so busy. . . they're not interested to say hello to you, you know. I was very depressed, for few years I was depressed, until I found a job, then I make some friends, you know. I still missed my family.

Vinita (age 51) talks about mental health:

> This is a big issue; people don't want to call it mental health but we all suffer from it. No action wants to be taken. I suffer due to family life not being ideal. There is a problem among our men of unemployment - it is rampant. This is a blow to the male ego and leads to drinking. Many men are verbally

> abusive. A high percentage are. This affects women's health but they are quiet about it. For me, I keep busy to empower myself and to build self esteem. What I don't get at home I get through community activity. Many women are afraid to act - they think no one will understand. To talk about it is taboo so they try to minimize the problem. My husband is unemployed and in poor health. He is a diabetic and a very heavy drinker. Many wives and children suffer from drinking husbands. Drinking and drugs are a huge issue for Fijians. I feel that eighty percent of Fiji families in Vancouver are affected.

Service providers also indicated that while severe mental illness did occur among immigrant women, as it does among all women, it was not very common. The term depression was used more to describe emotional upheaval and the anxiety and stress surrounding adjustments in everyday life, or reactions to family problems such as financial difficulty, spousal abuse, or the arrival of a new baby.

Marie, a settlement counsellor, relates an example of how depression may be expressed by a South Asian Fijian woman and how service providers may approach the perceived problem:

> I have on many occasions, when public health nurse visits the new mother and the baby they call our office and say, you know. . . I don't know. . . I feel this woman felt in that. . . she was quite depressed. She wasn't very open to talk to, she was worried about many things. I feel something is going on in the family. Could you please go visit and check. . .you know, find out what is happening. Sometimes we would pay the first visit together and see what's happening there, you know, and sometimes it's things like, if a girl is born, supposing the family was looking forward to have a boy, and the girl is born, poor mother

> gets very poor treatment at times, which she doesn't deserve under any circumstances, and if it was back home where she had her own family to support her, she would not have gone through that. . . you know. . . depression.

In this study thirteen of twenty women had experienced or were experiencing some type of stress in their lives that they said related to the impact on their families of living in a new country. These types of stress were experienced as the result of verbal or physical abuse, divorce, alcohol abuse by a family member, desertion by a spouse, communication problems between family members, child rebellion, or discord in the family. Six women had experienced more than one of these stress situations. Seven of the women described the problems as ongoing while six described the problems as in the past. Four women have sought counselling and have maintained their jobs and some degree of family life in spite of their difficulties. Some women's problems were just beginning as in the case of two refugee claimants. These women had left problems behind in Fiji only to find a host of new ones upon arrival in Canada, such as the inability to work due to immigration status, financial problems, loneliness, homesickness, separation from children, lack of a family support system, and lack of affordable housing and transportation. Five out of twenty women interviewed described women they knew who were having problems of some sort in their families, but stated that they themselves were

fortunate not to have experienced difficulties. Four of these women had lived in Canada or British Columbia for over twenty years and were very settled. Two women stated that spousal abuse or alcohol abuse never took place in the South Asian Fijian community at all, and one said that abuse was rampant in the Punjabi community.

All nine service providers indicated that emotional health issues were very important for all immigrant women and that the problems experienced by the South Asian Fijian women were not uncommon. It must be kept in mind that these service providers, especially the family counsellors (three) tend to see women who are having problems, which may be only the "tip of the iceberg". Another is careful to state that these problems are not the norm in any cultural group. These comments may be somewhat confusing in determining the actual numbers of women suffering abuse and other problems, but what is important is that "some" women are. That has been enough in recent years to lead to the creation of support programs in the community. It is difficult for women to take steps to seek professional assistance for their problems, however, especially when, as in the case of South Asian Fijian women, they do not usually discuss family problems outside of the family. Marie elaborates on this issue:

> And on top of that if she's gone to see someone outside and talks about her problems that's going to bring more problems into her family life. This is what she thinks. Once they walk into our office and after that we talk about this confidentiality and stuff,

> they understand and then they start opening their hearts out to us - but to walk into our office - very big step, major step in their life - their family problem, oh they are going to go and speak to somebody outside the family. It is a very big thing - what if my husband finds out - he'll never allow me to go back to his house ever again - he'll never be the same with me. . . so those are sort of worries she carries around with her and sometimes it turns into sleepless nights or she goes to the doctor's office and usually they give her anti-depressant pills, and she worries about that - what will be the side effects, if I had this, doctor doesn't understand what maybe her problem is, why she can't get to sleep - sometimes it goes so far that it gives birth to other mental diseases and problems.

When Marie was asked if the women she sees ever talk about their physical health, she stated:

> Not all the time. . .again the reason for that is that when we meet these people you know they have gone through their medical examinations and only, as you know that, only people who are medically fit are coming here. So, . . .no, but at times yes, they talk about stress, they talk about headaches, they talk about sleepness nights, those are the things that yes, they do talk about. . . and which going to a new country and a new environment, sometimes, you know, people can feel insecure.

Again, the health problems mentioned are related to mental or emotional well-being. Headaches may be caused by a disease, but are also often caused by stress, as is sleeplessness. Sleep disorders are common among other immigrant groups as well, especially among refugees (Stephenson, 1993).

The interelatedness of physical health and emotional health becomes very clear when women describe the difficulties

associated with settling in a new country. Some of the most initial and important feelings experienced by new immigrants from Fiji are those of loneliness and homesickness. Marie says that:

> To my knowledge, women are more in number than men for this. . . again because it's women who has to adjust to, and give more to the men's style of life and when she comes to a new country, the whole family structure is lost. She comes to a completely new environment, back home neighbours are the best friends, best relatives, she doesn't have that neighbourhood support, she doesn't have support from her immediate family, she doesn't have support from society at large, so she is a very, a loner, right in her own home. And then, children. . . supposing a family has moved with three kids and the mother. . . father is usually here before and then brings the mother here when he has adjusted himself, has a good job, has a place to live and made all those arrangements for his family to arrive. The same man which left three years ago or five years ago - the wife doesn't find the same man here. . .so that is the first shock. So he has now adjusted himself to the Canadian ways, she is very new here. She sees the change in the lifestyle and she thinks, "oh, my husband is not the same which used to come right at five in the evening. . . when he was at the farm I would take lunch to him - we would sit down and have a heart to heart chat" that sort of stuff. . .the family changes and the woman takes it to heart, and she doesn't know why that is happening for her.

Uma states that "loneliness and homesickness are seen immediately with the new women who come". She goes on to say that:

> but in terms of depression it's older women. You tend to see more in women about the age of forty or fifty a lot, and it's known here in Canada that women who are immigrants who have say, any sort of mental problems, they go to the doctor and just get tranquilizers and so

> you end up seeing a lot of immigrant women on drugs. And so...so basically I think that is what is happening because the system doesn't seem to be responding in the appropriate way the so they tend to give them tranquilizers and send them home and that is the end of this whole story.

Nazmeen (age 39) reflects on how older women may be more adversely affected by migrating to Canada:

> I think that at certain age groups people are more depressed. I feel that it's the people over fifty that come here that are more, maybe, mentally affected in that they are lonely. Because in Fiji the lifestyle is different. Like if you lived in the same neighbourhood then you knew everybody and you just sort of in walking distance to everybody and the socializing part - you didn't have to depend on anybody to take you anywhere. But once you come here, they're in a house, they're in an apartment with family that is working, children that are working and they end up taking care of the grandchildren. They don't have that independence, they are dependent on somebody - we know of a couple of people who are just stuck in the house because the son and daughter-in-law are working and they are depending on somebody to come pick them up. They themselves are not able to just hop on the bus and go anywhere.

Conceptions of "home" are altered when women move to a new country. Many women referred to Fiji as being "back home". Others have chosen to call Canada home, now, but will always have close ties with people and places in Fiji. Most women are reflective about Fiji as their place of origin and speak of it fondly, while accepting Canada as their new home. Prem (age 52) says:

> It's lovely to go back. Well, I think, you know if you like it, you lived there! People are quite friendly, it's not as clean as here, it's not as fast as here, everything is old style mostly. . . I still like it a lot. . . As for Canada, well, then you start to get used to it and then you get sort of in the middle, you want to go back, then you want to come back here.

Marie commented on the added burden of work that women often take on when they emigrate. This added burden of work affects the entire family and impacts women's physical health, emotional health, and their roles as providers of care in the home. The impact of increased work and role changes take their toll on self-esteem and feelings of self worth. Marie explains:

> If he sends his wife to work which he is not used to, she is home an hour late, he is suspicious. So, all those afflictions start in the family and the woman takes it too much on her, and she thinks she is the person who is guilty of all this. Why, if she hadn't done this, if she had come home only on time, husband wouldn't have thought of this - so all of these things she takes it to heart and you know, her self-esteem goes very low, sometimes financial crisis, all this family violence, especially battered, you know battered women, women are being battered in these kind of situation - you know she is the one who takes it all. If husband has problems out at work he will come and take it out on his wife, and she is the one who is taking it more. . .

The above are problems which families and communities are struggling to come to terms with. Some of the answers lie in culturally sensitive or "contextually aware" solutions. One

service provider, for example, referred to a program for men at the agency where she worked which counselled repeat spousal abuse offenders in a "culturally appropriate way". This means that the approaches are grounded using examples which these men can relate to. Surinder refers to the struggle to make family abuse unacceptable in all cultures but acknowledges the difficulty because of longstanding beliefs:

> Violence occurs across all cultures. It is due to conditioning. Men believe in power and control. . . It is not due to unemployment or the stress of adaptation. It is the job of the wife to sacrifice herself and nurture the family.

It is easy to focus on negative experiences of women when some accounts are so vivid and in some cases, so shocking. It is necessary to know that there are many women who are dealing with extreme problems which impact upon their health and well-being. But there is a danger in assuming that all, or most immigrant women experience abuse and marginalization because this is not the case. It is also necessary to focus on positive experiences, and experiences of women who, while they may have problems, or had problems in the past, are coping well. One of the most positive findings of this study was simply being told about the strength and coping skills of women time and again. Institutional and family support systems are there for some South Asian Fijian women, but not for all. These systems may also be sources of constraint and unhappiness. The balance lies somewhere in the middle where South Asian Fijian women, within the context of their own

families, are able to deal with problems, with support from the community. Education of both mainstream and immigrant communities is necessary in order to foster understanding toward different belief and value systems. Uma provides her insight into the perception of problems in the South Asian community in Vancouver by the mainstream (dominant culture):

> People sometimes say well, the extended family. . .you're always fighting between yourselves, you know the family members, you always hear about mother-in-law and daughter-in-law not getting along, but I think that is in any family dynamics that go on and at the end of the day, yes, we still very much family oriented, very much into large extended families and carrying on. There is some change beginning to happen but still at the end of the day that's our socialization.

Surinder comments on spousal abuse and its effects on women, but is still positive about the future:

> Men have more freedom - may have affairs and this leads to tension. Stalking and harassment is a problem. Men can't let go of control - they feel they own the women. This may happen when a woman finally leaves. Women must learn about abuse and that it is not acceptable. We must find disincentives for doing abuse. Abuse is prevalent, but there is a limited availability of homesharing for women, for single mothers - places where women can live alone and use support services. The mental health of abused women is important. They have no self-worth, the community ostracizes them, they can't earn a living. So they don't leave. They are economically dependent - they are socially dependent and cannot leave the home. Then there is a huge impact on the children. The role model is important and perpetuates the problem. . .we need to do something for the children. But I am optimistic. The generations onward will be more aware.

Surinder also emphasizes the importance of context in all

aspects of health experiences of immigrant women. She states that brochures translated into a woman's language are not enough - those brochures have to contain information that is meaningful to the everyday context of these women. Health services should be delivered with an awareness of context and women have to "find a comfort level; that is the balancing of two cultures and one's individual beliefs."

5.2.3 The Health Care System

Overall, women in this study had positive things to say about the health care system in British Columbia. While specific difficulties are mentioned, particularly in regard to hospitals and to initial access to health services by refugees, women see the health care system as a positive aspect of life in Canada, and perceive the services to be better than those available in Fiji.

Negative responses to the health care system and specific health services were more often expressed by service providers. Because these service providers worked in the health care system or had knowledge and experience of the system (through experience as settlement and family counsellors) they were able to pinpoint certain areas of weakness.

It should be noted that health care services in British Columbia are used by the women in this study in conjunction with the holding of traditional South Asian beliefs about

health which are also informed by indigenous Fijian ideas (Gill, 1988). Women, especially older ones, will exhaust their knowledge of "home remedies" or traditional treatments of a health problem before visiting a doctor. Six women use or have tried what mainstream health professionals currently refer to as alternative treatments, such as Chinese medicine, massage therapy, or holistic health management.

While women did praise the health care system in general, they did often state that doctors, male or female, did not listen to or spend enough time with them. They said that doctors often gave them some pills and sent them home. When asked if they consulted a doctor about issues that were bothering them, many said they did not tell the doctor at all because they did not feel the doctor would understand. Some women do not tell the doctor what their problems really are, or ask any questions because they consider the doctor's word as final; the doctor has expert knowledge that must not be questioned. One woman described this attitude as thinking "the doctor was like god" - and one should not question that judgement.

Women access the health care system based upon information provided to them by family and friends. The family network is effective in this regard, as doctors and services that families are using are recommended to new arrivals. Many families know of specific doctors who speak Hindi, or of women doctors who are taking new patients. Many

women mention their relief at having such excellent health care at their fingertips. Some mentioned, however, that health insurance coverage should be available from "day one" in Canada.

Problems arise in cases where women are in Canada alone as refugee claimants, and have exhausted the free emergency medical services available to them, or as wives who were dependent upon their husband's sponsorship for medical coverage and who have been deserted or divorced. In this particular sample, two of twenty women fall into the latter category.

Eleven of the women used more than one health service, with the most frequently used service being a doctor (Table 5.3). Most women (fourteen) preferred the services of a

TABLE 5.3

HEALTH CARE SERVICES USED IN PAST YEAR

Service Used	Clinic	Health Unit	Hospital	Dentist	Doctor	Other
No. of Women Using	7	4	2	6	14	6

family doctor and had visited the doctor in the past year or so. Women described walk-in clinics as convenient, but not really their choice of health service unless they needed a doctor on weekends or after working hours. Health units were not used very often except in the case of services for new

infants and children, or injections for travelling. Only two women had had hospital experiences in the past year, but five women over age sixty had been in hospital at least once in the past decade. Women often described hospitals as a last resort where one went only when seriously ill, or to give birth. If women were able to afford it, or had dental coverage through their employer, or their husband's employer they went to the dentist. Dentists were usually found upon recommendation by family or friends. Dental services were generally considered to be very expensive. For example, Indira (age 34) described having dental work done on a recent visit to Fiji (where it is heavily subsidized at outpatient clinics) because she has no dental plan and cannot afford to pay the dentist in Vancouver.

The following accounts of individual women illustrate the their perceptions of health services. Shamina (age 48) states:

> I think health really means so much for me. Because when I was very depressed, I was very depressed when I came here because my husband was sick. Because of the *coup* he had a mental, you know, affect. Because he was in the politics all the time, so that is why I was affected. I had to look after him and I am very lucky to be here, because as soon as I came here I saw a psychiatrist. And through him, this psychiatrist, he's really good, I mean to say healthwise he is very good, and if I was in Fiji, as you know, the health is not that good in Fiji, the medicines and all that, the doctors, the doctors are good, but it's very hard to get the medicines there and that is why I am thinking that if I am here, good thing that I am here, you know and survived. I got sick too and I had a very nice treatment here and that is why I think that the health system here is very good - we have got some

> top doctors here and they care for you and worry about you so the health system is really good.

Sita (age 21) describes how access to health services for her changed as her marital status changed:

> When I came to Vancouver after marriage I was covered under my husband's plan. When I came back the second time after divorce I went into the welfare channel. Where I work I now have coverage on the Provincial plan and I got dental coverage after one year of employment. At first I had to pay for medical expenses up front and then claimed them on my income tax. But, you have to go out and reach the services and help for me was provided by the community liaison at OASIS.

With respect to comparisons made by individual women, the British Columbia health care system was typically more highly regarded than the Fijian. There were essentially three factors which contributed to this assessment. First is the issue of affordability. While Fijians enjoy universal access to primary health care, the level of quality is such that a two tier system has evolved whereby in order to secure high quality care, those who can afford to do so pay substantially higher fees to private physicians or go overseas. Second, individual women reported greater access to high tech health care facilities and services (routine ultrasound, greater range of prescription drugs, specialists) in British Columbia. This is not surprising given the infatuation that many developing countries have with western high-tech models of

medicine (Mills and Lee, 1993). Finally, participants who had experienced a hospital stay in both Fiji and B.C. approximately one-quarter of the sample) typically reported better quality care in B.C. hospitals. One potential explanation for this, mentioned by several participants, is that subsequent to the 1987 *coup,* there was a flight of expertise as most health care professionals sought more stable working and living environments elsewhere. The gap was essentially filled with indigenous health care workers whom, as at least three individual women implied, gave varying levels of care to South Asian and other non-indigenous Fijians. Overall, therefore, women reported that the health care system in B.C. was a positive aspect of the migration experience.

Individual South Asian Fijian women seem more confident in the health care system and the services offered than service providers. Service providers have a different perspective on the use of health care services and problems encountered by immigrants. Service providers often see problems first hand, but also see how the system is successful. Surinder praises community services:

> Who provides service is important. Community and neighbourhood services are a good thing. They must not separate everything - this leads to marginalization and then the mainstream is not taking responsibility.

The latter part of her response refers to the idea of separate health services for separate cultural or marginalized groups.

Surinder sees community services as one way of providing care to all people within one health care system, but within a system which is sensitive to specific needs at the community level. In a similar vein, Uma states:

> I believe in mainstream care - I believe that we should all become culturally more sensitive and provide more culturally appropriate care and sometimes, who knows, we might learn from one culture something like that, something from the other cultures too.

The idea of separate services and facilities, for example, hospitals which cater to people with different languages and cultural needs was discussed at length with service providers. Service providers generally think that adaptations to existing health services should be made in order to respond to a variety of cultural needs and approaches to health within one system. This may be done through education of health professionals, public education, and health policy.

It has been well-documented that hospital services in particular are inadequate in meeting the cultural needs of many patients (Anderson et al, 1990; Dyck, 1992; Stephenson, 1993). Service providers felt that definitions of health had to be broader to include non-western ideas of health and that alternative approaches to health care had to become more accepted. Surinder states that "integration of health services must take place at every level. Marginalizing of services does occur and tends to increase isolation."

Uma recounted her personal experience of home care services for her elderly mother and analyzed the situation

from the perspective of both a health service provider and a consumer in the South Asian community:

> Well, I find the system doesn't make the home care more functional, I mean, for example, my mum was sick and came home from hospital and she was going to stay with me for a while so we had to report to the Home Care Services and Long Term Care so they were going to send a homemaker in, well the homemaker made it more pressure and stress and more difficult for me than to be effective because they don't do anything that is not the client's - so if you wanted to do laundry, they will only do mum's laundry and if she only had three items that's all they wanted to throw in the washing machine - and do that, so it was do her laundry, do her bedmaking, do her bath, only sort of vacuum around her bed. . . it was easier to do her laundry when I did my laundry because to me it didn't make sense to have them throw 3 items in the washer and so I would just say "forget it, I'll do the laundry myself" so ok, then the woman would just sit there and do nothing - it was like ok, I have come to put my hour in but I will only do so and so and there was no trade-off for anything with them . . .And so, things have to be changed and that's why for Indian families some of these homemaker services don't work. They work fine for maybe in the western culture where you do have the older family, elders living on their own in their own homes and yes you need someone to come and vacuum their houses and come and do laundry and mop - because they are the only ones living in that home. But here when you are living in extended family those kind of policies don't work where they say "I am only going to vacuum her room and nothing else," you know "I'm only going to wash the parts she stepped on, " kind of thing, and nothing else and so it was like why bother?

The process of health policy change is also perceived as problematic. The lack of coordination surrounding

multicultural health concerns leads to the "putting out of small fires" instead of addressing the overall meaning of health policy. One service provider asks these questions about health policy: "What is the extent to which realistic services will be provided by the government. . .and where? . . .at all three government levels?"

According to service providers there is a lack of clear definitions, parameters and enforcement surrounding multicultural health policy. Surinder feels that health service delivery problems are due to the following problems:

> There is no vision. Service is fragmented. There is token training in multicultural health care delivery. Staff must be trained in what is most important in multicultural health care and how this impacts on daily work. This must flow from policy which is enforced and evaluated. The white fears, the government should deal with these. The role of government is to make multiculturalism and immigration understood. It must be made clear who is actually taking away jobs - is anyone really? It must be made clear what multiculturalism means and why we are doing it. Power politics are at play here. How do we define the parameters? Many agencies are engaged in empire building. Who provides service, the clear mandate and so on, these important issues are lost in the exercise. The flow must be back and forth - failure now comes from lack of direction.

Health interpretation is another important aspect of a sensitive, functioning health care system often mentioned by service providers. The mechanisms to provide interpretation and materials in many languages are steadily improving in Vancouver, especially since the creation of a position in the

health department dedicated to multicultural health concerns. Within the constraints of a limited budget, the person in this position ensures that health promotion material is translated and produced, and also educates health professionals about issues surrounding multicultural health. But there is still a dearth of health interpreters and material. Older people especially, would benefit from increased services, in order to relieve the pressure surrounding traditional family roles and to foster effective communication across cultures.

It is important to see the points of view of both individual women and service providers in regard to the health care system. Service providers are working with the system on a regular basis and have insights into structural (system organization, for example) factors which may or may not facilitate the most effective health care delivery to immigrant women. Individual women have expressed overall satisfaction with the system but also reflect on ways the system could be more sensitive to their particular needs, particularly surrounding language and cultural practices. It is important to note that in spite of the success that most South Asian Fijian women in this study have experienced with the health care system in British Columbia, there are women whose needs are not being met.

5.2.4 Women's Roles as Health Care Providers

Historically, women in all cultures have provided health care in the context of the family and, more recently, in formal roles as health professionals (Heller, 1986; Benoit, 1991).

Women's roles in South Asian Fijian culture are traditionally well-defined and have been centred around provision of care of the family in the home (Buchignani et al, 1985). This not only includes care of the sick but all other aspects of providing for the well-being of the family such as counselling children, cooking, cleaning, shopping and social activities. These roles are often upset, interrupted or reversed upon migration to a new country, often due to economic pressures. Women may be working outside the home for the first time in their lives, and the family is greatly affected (Anderson et al, 1990). Not all women are working outside the home, but the pressures of family life are still there and care of the family is a twenty-four hour a day job in itself. A good example is related by Marie:

> They are still trying to do it all. Just because it's so difficult for the other family members to understand their point of view, so in order to avoid conflict and problems they complain to that effect. . .this one mother was telling me, she said "my son came home at two in the morning, and said mum, where is my food, where is my food and I was fast asleep and my husband came and says hey, get up, your son is looking for food and if you didn't cook then go cook now." There is a lot expected.

Women often consider care of the family of prime importance in

their lives. They place their families' needs before their own and define their self-worth by their familial role. Marie continues:

> So they take on so much and their personal health is not important to them at all, they think they are made of steel, they are very strong and nothing will happen to them because they are the care takers of the rest of the family. . . so their personal self is familial self and is the main goal here for these women whereas individual self is not important to them at all.

Surinder states that:

> women do everything; they are the ultimate care giver. Women do double work. This is unhealthy. There is no time for her - no social life; overwork impacts on all parts of her life.

Surinder thinks that women are also enabling this burden to continue. She really feels women must change if men's attitudes are to change, that is, women must stop working so hard. It is difficult and frightening for women to change, however, if they are emotionally, socially and financially dependent upon their roles in the family. Surinder states that women alone have the power to stop the overwork burden and the negative impacts of role changes. She states that women must support one another, although in South Asian culture this is still not very common, perhaps due to the fear of identifying with someone who goes against social norms. Surinder uses the example of her own situation as a divorced South Asian woman to describe this: "Divorced women are

ostracized - I am divorced. It took a long time but the community now accepts me. Many women are too fearful of this ostracizing to act."

Vinita (age 51) speaks about the multiple roles she plays as a caregiver in her family:

> I go out of my way to care for my family. I am very aware of my place in the family and consider myself a role model. I give advice, I am a social organizer, an advocate and a counsellor - all in my own family. My older parents looked to me for their care after they came to Canada. My mother lived with us until she bought a house - but she still comes to sleep with her daughter. She does her own doctor's appointments. I feel that the best professionals can't fill the shoes of the family care. As far as my role is concerned I see myself as one who would go out of my way to provide care - I receive less but have more to give. My family do appreciate my contribution once in a while.

According to Kalbash, the care of handicapped children is particularly difficult for some South Asian women because of the "negative karma" surrounding the handicap. She states that many women never come to terms with providing care that is suggested by occupational or physiotherapists. Rather, they spend time grieving and hoping that a miracle doctor will solve the problem. She provides this story as an example, however, and not as a generalization.

Traditionally, in South Asian families, including those from Fiji, the son provides care for his parents, but it is his wife who is actually responsible for most of the tasks involved in this. This is also true if a family member is sick. Uma describes the situation which may occur when both

the son and daughter-in-law work:

> There have been situations where the daughter-in-law and the husband, they are busy and there is neglect of the sick and there is this whole family problem and conflict. So you do see that. But definitely women care for the sick people, in the home and in the community. Sisters-in-law will drop in on a sick woman, look after her, bring food and so on.

Women see their role as providers of care in the family extending beyond the parameters of her home into the community. As indicated above, other women care for women when they become ill. Women also spend much time at the hospital if a family member is ill. One of the most common places or spaces of conflict between health professionals and patients (and patient families) who are unfamiliar with biomedical values, has been the hospital setting. For example, nursing personnel may become impatient with the continual presence of family members at a patients' bedside if this interferes with strict hospital routines, or, the hospital diet will often create problems for patients not accustomed to western food.

Vinita (age 51) feels that the government should pay more attention to the resources available in families. She feels that families must be responsible for looking after their own. "It would cost the system less if people were paid to care for their own family members; if you were paid for it. The problem for some women is if you care for your ill family - you miss work."

Adult women are not the sole caregivers in South Asian

Fijian families. Children may be asked to step into a caregiver role if necessary and there are many men who willingly care for sick family members as well. Children often play the role of interpreter for parents or older relatives whose English is not sufficent to allow them to communicate fully with medical personnel. This can be very helpful, but also very stressful for adult and child. Many adults are unwilling to discuss intimate medical details in front of young people and so may not communicate the full nature of their problem to the medical personnel. Interpretation is problematic - there is no guarantee that proper communication is taking place. Many adults are distressed at the role reversal which takes place when children act as caregivers for their parents because children will often speak English around them and make them feel left out of the conversation, or will not take the advice or points of view of the parents any longer.

5.2.5 Summary

South Asian Fijian women and service providers who work with them, state clearly that health means more than physical fitness. Health comprises the physical, emotional and spiritual aspects of a person's life and ability to function well in family and community. This conception of health is broader than traditional biomedical conceptions of health, and informs expanding definitions of health in the policy realm.

Physical health problems are experienced by South Asian Fijian women but do not seem to dominate perceptions of overall well-being. Women tend to have more immediate worries about their children or family situation than about their physical health. According to service providers, older women frequently suffer from hypertension and diabetes. Service providers feel that the prevalence of these diseases among older South Asian women is rooted in the social system. Younger women seem more vulnerable to reproductive problems, and again service providers attribute dietary and other problems to changes in the social system. Most women report fatigue as a very common physical state related to the multiple work burden both inside and outside the home.

Emotional health and well-being dominate the overall picture of health for South Asian Fijian women according to both individual women and service providers. Most women acknowledged that if one felt well emotionally, then one's physical health followed. It is a challenge for a woman to achieve emotional well-being if she has family, economic, or marital problems, has been abandoned, or abused. An overriding and positive result of this research is the seeming ability of women to cope with many kinds of situations. While there are many problems which must be addressed, these women are strong and report coping well. Coping mechanisms include spiritual development, finding an outlet or source of support at work or in the community, or focusing on children in a

difficult marriage. Importantly, there are also women who feel happy and satisfied with their lives.

Most women express satisfaction and respect for the health care system in British Columbia. Most women use doctors and have found a doctor they like through their family and community networks. Service providers are more critical of multicultural health care provision but are hopeful that further training and education of health care personnel as well as community and social workers will improve the sensitivity and appropriateness of mainstream health services.

Women's roles as health care providers are important in the context of family and community and also reflect changes in women's roles generally. Upon migration, women attempt to keep up their role as a primary provider in the home, whether or not they are working outside the home. These roles can change upon migration however, which can create stress in the family. Some women feel that their roles as providers of care in the home and community could ease the burden of care provided by the formal health care system, particularly if caregivers at home were paid for the work. At times women feel frustrated that their family does not seem to appreciate their roles, and the work that they do to care for family members.

5.3 The Social Construction of Health in Place

The previous sections have addressed the first two research objectives, that is, the documentation of the health concerns of South Asian Fijian women and the linking of health status with the immigration experience. The following discussion addresses the third objective, to investigate links between ethnicity and health in place for South Asian Fijian women.

The theoretical framework informing this research in health geography is based on social constructionism which seeks to illustrate how health and health care experiences are constructed through cultural, economic and social processes. These processes in turn influence both the dynamics of migration from Fiji to Vancouver, and the experiences of women who have made this move.

The health of South Asian Fijian women in Canada is partially determined by historical factors leading to migration and the subsequent alterations to the "Fiji" blueprint of social constructions, that is, the socialization process. The architectural drawings forming the basis of the social construction of "home", and major institutions such as the family with its attendant roles, are fundamentally altered when exposed to Canadian society. For example, for Mrs. Gopal (age 59) "home" is where her family is, and she is fortunate in that having defined her roles in relation to her family, she has made the adjustment to Canadian life quite smoothly

(Section 4.4). But Kirmina's (age 21) "home" is unlike anything she ever experienced in Fiji, and she is having difficulty adjusting to life in Canada (Section 4.2). Also, different constructs of health, illness and disease are institutionalized at the societal level in both Canada and Fiji. For example, the differences between the dominant biomedical approach in Canada and the more holistic approach in Fiji influence individual health experience, as exemplified by Mrs. Bajpai (age 84) who felt constrained by western approaches and wanted to use "jungle medicine", which reflected different ways of knowing about health (Section 4.5). Social constructionism, aided by the model "Contexts of Health Care Knowledge" (see section 2.3), illuminate how health and health care experiences are related to local contextual factors influencing health knowledge. For example, cultural conceptions of health are evident in the broad nature of South Asian Fijian women's definitions of health (Section 5.1), and the strong links women make with diet (Verinder, age 46, Mrs. Bajpai, age 84) (Sections 4.3 and 4.5). Second, the struggle for economic survival in a new country may impact a woman's health profoundly when she is expected to work outside the home, keep the home running and do all of this within the confines of her traditional roles, with or without the aid of social networks. For example, Govinda (age 40) is often very tired from working, as well as travelling to and from work, in her struggle for economic independence. Economic worries are

uppermost in her mind (Section 4.1), whereas Mrs. Gopal (age 59) considers it "nice" for her daughters not to have to be employed. Third, state regulations influencing immigration and health policy also play an important role in how health is achieved by an immigrant woman as she comes to terms with her new "place" in the world. Kirmina (age 21) exemplifies how the failure of her husband to fulfill immigration requirements for sponsorship has ultimately influenced her level of support which has in turn impacted her ability to take advantage of essential health services, and to achieve health in place, for herself, and for her baby. The researcher assisted Kirmina in using the telephone to call the health unit so that the baby's immunizations could be brought up-to-date.

The ongoing social construction of reality in certain places and localities enables a broader look at health in the context of women's "everyday" lives. The definition of "everyday" for the purposes of this study is informed by the women themselves (Sections 4.1 - 4.5), as well as the literature in social constructionism (Giddens, 1984) and medical geography (Donovan, 1986; Dyck, 1992; Eyles and Donovan, 1990; Eyles, 1993). The term is used in a common sense manner to reflect the things women do everyday and how they are able to do them. For example, Heller (1986) refers to recognizing and giving appropriate importance to a person's daily labour, in order to foster respect for those who contribute to the well-being of our social and economic lives.

She is speaking specifically in reference to women's roles as health guardians in the home, and refers to the meshing of societal expectations and women's desires to fulfill the day to day roles expected of them. Mrs. Gopal (Section 4.4) and Mrs. Bajpai (Section 4.5), in caring for their family and friends are fulfilling these roles on a daily basis. Govinda (Section 4.1) attempts to maintain this role, even while working, but struggles with the stigma of divorce and a changing relationship with her young son. Everyday life could be described as the hard core reality of what people do and experience, as well as those mind-wandering "shoulds" and "ifs" which may often influence societal expectations and individual decisions and actions. While Govinda may feel that she should be married, or should not have left her children in Fiji, in the eyes of those in her social network, she made the difficult decision to move to Canada to try and begin a new life (Section 4.1). Consequently, "everyday life" both constrains and enables action. Kirmina (age 21), on the one hand, is constrained by the fact that she has been deserted by her husband and is trying to cope with economic, social, and cultural change associated with her departure from an accepted social role in South Asian Fijian culture (Section 4.2). Mrs. Gopal (age 59), on the other hand, is enabled to carry out her familial roles on a daily basis, and this is reflected in the support she receives from those family members at home and living nearby as well as her good health and satisfaction with

life in general. Numerous further references to daily functioning (Sections 5.2.1 and 5.2.2), getting along in life (Sections 5.2.2 and 5.2.4) and physical health following on from emotional well-being (Sections 5.2.2 and 5.2.4) were made by the women. In addition, Buchignani et al, (1985: 171) quotes a South Asian immigrant who refers explicitly to the "everyday":

> I think that it is hard for the non-immigrant to appreciate all of the little things that are important to everyday life that we immigrants have to figure out for ourselves. Just consider the basic things to do with governments, such as social insurance, medical coverage. . . and so on.

It is interesting to note that emotional stresses which affect physical health are being experienced by women who are, overall, very positive and optimistic about the health care system in Canada (Section 5.2.3). But on the road to successful negotiation of the system and achieving well-being some women seem to experience, borrowing the words of Yi-Fu Tuan (1994), a "failure of place". Failure of place may occur when the institutions that women have been socialized into, change radically, or negatively and no longer provide emotional sustenance and the ability to feel comfortable with one's roles. Kirmina (age 21) is experiencing a "failure of place" which is contributing to her isolation and sadness, partially because she is geographically separated from her social network, but also because her place in the world is

undergoing redefinition as a divorced and deserted woman (Section 4.2). This may happen in the home with the immediate family, when children become very "Canadian" and no longer seem to respect their mother whose English is not very good and who wishes her children to maintain their "Indian" values. For example, Govinda argues with her son about his assertive behaviour towards her, and is concerned about maintaining her position of authority. This may happen in the extended family and social networks also, when divorced or separated women are ostracized (as in the lives of Kirmina, Govinda and Verinder) or when family dynamics affect older or younger women adversely, for example in the mother-in-law and daughter-in-law relationship of Mrs. Bajpai. While Mrs. Bajpai (age 84) moved to Vancouver to be close to her family, she does not always get along with them, and resents their efforts to control her life. Consequently, she is more interested in socializing with her women friends (Section 4.5). This is all part of the "culture shock" process and may contribute to women being suspended between what Taylor (1990) referred to earlier as "moral topographies" in that women must navigate between the varied value systems of both Canadian and Fijian culture. For example, older women in South Asian cultures typically occupy a position of authority in the family, and are often more independent than at any other time of their lives. The "moral topography" of Canadian culture is somewhat different, and in certain cases, the younger

generation of women in immigrant families usurps this role (Koehn, 1993). As in the case of Mrs. Bajpai's daughter-in-law, the younger women may wish to control the activities of the older members of the household, and may not be content to defer to them to the extent that they may have had to in Fiji.

Healthshock" (Bhayana, 1991), part of the culture shock experience, may also occur. Healthshock may contribute further to moral dilemmas when approaches to health and health beliefs (shaped by one's cultural topography) conflict with institutionalized health care. For example, Mrs. Bajpai has resigned herself to accepting that here in B.C. one must "do what the doctor says" in order to stay healthy. She feels constrained from using "jungle medicine", partly because the leaves and herbs she is used to do not grow in B.C., but partly because she feels it would not be acceptable (Section 4.5). She feels that a distinct loss of knowledge is occuring, because the younger generation of South Asian Fijian women is not interested in maintaining traditional health practices (such as post partum rituals). Service providers, while not referring specifically to healthshock, discussed many areas in health care delivery which could become more culturally sensitive. By specifically targeting health service delivery to such groups and making it more contextually appropriate, the health care exchange could be improved dramatically. Although South Asian Fijian women are positive about the health care system, they still complained

about doctors that rush them through appointments, or about hospital care that is deteriorating due to a lack of staff (Section 5.2.3). This is not different than many other doctor-patient relationships but the increase in distance due to language barriers or value systems in a cross-cultural exchange increases the risk of miscommunication. Healthshock may also occur however, when South Asian Fijian women place their trust in the doctor and instead of asking questions or discussing their problems, simply rely on the knowledge of the doctor. Vinita raises this point in reference to older women that she knows (Section 5.2.1).

Bhayana (1991: 29) suggests that immigrant women experience healthshock more than other women, and the dependence of some on their families to communicate on their behalf leads to disempowerment. Most South Asian Fijian women have the benefit of speaking English and surmounting some of these difficulties of dependence, but some do not, as in the case of Kirmina (Section 4.2).

Healthshock could be explored through policy avenues in two ways. First, through the education of health care professionals, and second, through the exploration of health beliefs that are not necessarily medically focused. Healthshock could then be seen as positive, where learning takes place in both parts of the patient-practitioner relationship and where cultural safety is guarded.

Service providers contribute an important dimension to

this study through their experience as public health nurses, health interpreters, family counsellors, settlement workers and employment counsellors. Koehn (1993: 36), in her study of elderly Punjabi women in British Columbia, found that testimonies of service providers may overemphasize the problematic nature of the immigration experience, while at the same time providing excellent insights into some of the vulnerabilities experienced by immigrant women. This proved to be the case in this study as well, and it must be kept in mind that in many cases the service providers were providing help to women who were in desperate situations. One service provider warned me that while some of the serious problems exist for South Asian Fijian women (indeed all women), they are not the norm. Conversely, another service provider warned that she sees only the tip of the iceberg and that the community norm for immigrant women, and again all women, is much worse that the small segment she sees who actually seek help. Service providers generally corroborated the experiences of South Asian Fijian women given their various opportunities and constraints based upon language ability, age, education, family situation, and immigration status. Service providers emphasize that many of the difficulties faced by women after arrival in Vancouver are not due to cultural factors alone, but to the combination of social, economic and political factors which impact on a woman's cultural background. In a multicultural community, where

cultural belief and difference is supposedly acknowledged (through legislated federal policy) as an integral part of the unique make-up of Canada, women in particular face many contradictions. One service provider spoke of immigration policy which refers to potential immigrants as assets to Canada and which gives the impression that Canada "wants you". Susan stated that "many people are unable to find any employment at all, let alone a job which reflects their training and skill. Then, a vicious circle of depression and unhappiness begins." Finding employment is a major constraint to the economic well being of the women in this study. While Kirmina is unable to work due to her immigration status, she may face additional barriers due to her lack of education and skills even if she attains a work permit (Section 4.2). Govinda feels depressed because she needs full-time work in order to attain her goals of sponsoring her sons, and to be decrease her economic dependence on her family (Section 4.1).

Service providers also referred to racism as a definite problem, one calling it "white fear" (of people from other cultures). Racism occurs at many levels, not just in an overt manner (such as the proliferation of racist graffiti which began appearing in Vancouver and Victoria during the late 1970s), but also subliminally (Buchignani, 1985). Prem (age 51) related a story about her past work in a day care centre in Vancouver, where she was a supervisor. Prem had been an elementary school teacher in Fiji and so had attained some

post-secondary education. She said that many times her colleagues asked her to correct their spelling or check their math; she was a well-respected staff member. But the parents at the day care centre would only consult her last, and she felt this was because of the colour of her skin. According to one service provider, racism still has a definite impact on the ability to formulate health policy which is contextually appropriate and culturally sensitive, and which is implemented and evaluated effectively.

Finally, for South Asian Fijian women, the strong link between emotional and physical health appears to be rooted in the complex social dynamics which occur upon migration, and is illuminated by a social constructionist approach to health in place. Social support (or constraint) networks, and role changes within families which often have a broader cultural value attached to them (women working outside the home), are just two aspects of life which are socially constructed and which affect the way women perceive their health. These aspects of life are exemplified in the women's profiles in Chapter Four as well as in their quotes in Chapter Five.

Social constructionism informs the goals of health geography which seeks to refocus on the experiential aspects of space and place. This research approach also provides opportunities to contribute to population health strategies which "address the entire range of individual and collective factors that determine health" (FPTACPH, 1994), and which

ultimately recognize the varied concerns of a multicultural society.

CHAPTER SIX: SUMMARY AND CONCLUSIONS

6.1 Summary

This thesis examined the health concerns of South Asian Fijian women living in Greater Vancouver, British Columbia by addressing three research objectives: (1) to document the health concerns of South Asian Fijian women living in Greater Vancouver; (2) to investigate the links between perceived health status and participants' perceptions of the immigration experience; and, (3) to investigate links between ethnicity and health in place for this particular immigrant group. This research involved women from the community, who also made suggestions toward the modification of health policy.

The scope and context of the research were established in relation to: (1) the gaps identified in the literature; (2) revised health policy goals of the British Columbia government in seeking a broader definition of health; (3) and the researcher's investigation of primary health care in Fiji. The history of South Asian Fijian experience in Fiji and Canada was followed by a literature review which places this research within the context of a health geography informed by an interpretive social constructionism. This approach explores links between traditional theoretical frameworks in medical geography in order to inform a growing body of research in health geography which considers place an integral part of health experience, rather than a container or spatial unit.

The research focused on the Greater Vancouver area of British Columbia because of recent immigration patterns of South Asian Fijians to the Province, and because of the researcher's life experience in Fiji. Nine service providers who work with South Asian Fijian women and twenty individual South Asian Fijian women participated in the study.

The research was designed using a qualitative approach which employed open-ended depth interviews using a checklist of topics as a guide. The researcher encouraged women to talk about a variety of health concerns and experiences. Depth interviews were tape recorded, transcribed and analyzed using a primarily inductive approach. In the final analysis, the dominant relationships between coded interview segments were found to link physical and emotional well-being as well as women's changing roles in the family upon migration to women's views of their health concerns.

Five major themes represent the results in this study. The first theme, meanings and definitions of health, provides a basis for discussion of subsequent themes. The health experiences of participants are summarized under a second set of themes comprised of physical health, emotional health, the health care system and women's roles as health care providers. These major themes are not mutually exclusive, but represent major issues of concern among South Asian Fijian women and the service providers who work with them. It was found that the link between emotional and physical well-being is rooted in

migration-related experiences which often impact upon women's roles in the family. For example, Govinda (age 40) is now working outside the home, is divorced and is a single mother, all roles not typically acceptable for South Asian Fijian women. Her health experiences are determined in conjunction with her negotiation of her new roles in a new country (Section 4.1). Health in place for South Asian Fijian women is essentially socially constructed and mitigated by cultural, economic and political factors. For example, Kirmina (age 21) cannot work due to her lack of legal status in Canada, has very little money, and is cut off from her social support network since she attempted to join her husband in Canada (Section 4.2). The appropriateness of the theoretical framework and methodology are borne out in the results which inform health policy from the perspective of the community user of health services.

Health policy which seeks to find a broader definition of health, and meet the needs of "target" groups (such as immigrant women) could benefit from the development of research programs which seek community input. The challenge lies in addressing the differences between individuals (intraethnic diversity, for example) through health and social policy which is designed to serve millions.

6.2 Methodological Considerations: Empowerment and the Goals of "Feminist" Research

This research did not begin within a specifically feminist framework, but in employing a subject-centred approach which sought to find meaning in women's responses, the researcher was soon confronted with issues of gender and empowerment. It is quite possible that this research represents a step in an evolutionary process toward developing a feminist strand of theory in post-medical geography (Litva et al, 1995), but like heart health research (Elliott, 1995) and other research with women in medical geography (Williams, 1995), this study may only challenge gender blindness in the sub-discipline.

The issue of empowerment of participants through the research process was an important and complicated one in this study. While the study involved women directly in research, and their responses as much as possible form the results, the role of a white, outside researcher was very important. The researcher's goal was to facilitate empowerment through increased understanding between women and to possibly make women aware of their own ability to act, through the interview and discussion process. For example, the researcher was empowered when women agreed to participate in the study, and when she learned more about women in another culture. Alternatively, when women were made aware of health or social services or were relieved to share their problems, they often

made statements to the effect that it "is good to talk about these troubles". Sharing and gaining information is often a first step to self-determination and self-direction, part of the process of empowerment (Dennis, 1991; Opie, 1992).

Political action did not take place within the confines of this study. But political action is the key to legislated social change, which includes social and health policy. Therefore the voices of South Asian Fijian women are important in what they have to say to policy makers in relation to their definitions of health, experiences of the health care system and the dynamics of the immigration process and how their lives are changed upon moving to Canada. Their voices are important, NOT as problem-laden immigrant women's voices, but as voices from the community.

While the researcher had as her goal, the empowerment of South Asian Fijian women at some level, the research process in fact may have empowered the researcher more than the participants. Research participants acknowledged the research process in many ways and wanted their stories to be told, but the researcher had to question exactly how their empowerment was taking place. Were they taking something from the researcher in order to be empowered? Was the researcher giving them something? Or were researcher and participant sharing something? It may be presumptuous on the part of researchers to assume that "oppressed" groups require empowerment or that certain groups are "oppressed" in the

first place; could this possibly create or reinforce their oppression? As Stephenson (1994, pers. comm.) states:

> To give power is perhaps impossible. . . a smoke screen in our ideology for a more subtle preservation of power relationships. To empower another entails drawing attention to their very lack of power. . . they are so powerless that you must give power to them. . . people may take power and create pressure for power-sharing but I doubt that it can be given to people.

The researcher did not explicitly choose methods that some label as feminist (Harding, 1989) but it was found during the research process that goals of feminist research linked well to the goals of this thesis. This thesis research also underlines the ongoing dilemma in research, particularly cross-cultural research, of how to canvass "ordinary" people in the community and involve them in the research process. Armed with an awareness of cultural safety and the risks and biases associated with cross-cultural research, or any research with "oppressed" groups, researchers must make the attempt to engage new research directions. As emphasized by England (1994: 81): "The openness and culturally constructed nature of the social world, peppered with contradictions and complexities needs to be embraced, not ignored."

6.3 Conclusions

The discussion of results in this study converge around theoretical, methodological and substantive contributions.

6.3.1 Theoretical Contributions

The theoretical approach employed in this research, a social constructionist geography, was useful in illuminating how health and health care experiences are socially constructed in relation to cultural processes. For example, cultural conceptions of health are evident in the broad and varied nature of South Asian Fijian women's definitions of health (Section 5.1). Women consider diet as an essential component of health and concepts of balance as exemplified in the labelling of hot and cold foods are examples of health knowledge which inform approaches to everyday life (Sections 4.3 and 5.1). Also, traditional knowledge comprised of Indian practices, indigenous Fijian practices and western medicine inform the way South Asian Fijian women approach health. These approaches contribute to a holistic sense of health which makes explicit connections between physical and mental well-being (Sections 4.5 and 5.1). Second, the struggle for economic survival in a new country may impact a woman's health profoundly when she is expected to work outside the home, keep the home running and do all of this within the confines of her traditional roles. Again, women are often working outside of the home for the first time in their lives, and may be fulfilling new (and possibly stigmatized) roles in the process. For example, Govinda (age 40) is a single mother, who left her abusive husband and two of her children in Fiji. She is divorced, left her children and is now working part-

time with an irregular schedule. She no longer fulfills the ideal picture of a "good Indian wife" and is struggling to come to terms with this in the South Asian Fijian community. Also, her adolescent son is beginning to speak out to her, which she finds disrespectful. All of these factors contribute to a general sense of depression and homesickness (Sections 4.1, 5.2.3 and 5.2.4). Third, immigration and health policy also play an important role in how health is achieved by an immigrant woman. Health policy determines the accessibility of health services, and immigration policy determines the presence or absence of other members of the woman's family (social networks). Kirmina (age 21) has a very limited social network, and has also failed in possibly the most important role for a South Asian Fijian woman, that of being a "good wife". Her husband rejected her and she is literally adrift, attempting to redefine her roles, and consider her options in a strange place. Returning to Fiji may not be acceptable for Kirmina either, because the rejection of Kirmina as a wife, reflects a rejection of Kirmina's family as well. The failure of Kirmina's husband to fulfill his legal obligations of sponsorship through the immigration process, has ultimately affected Kirmina's ability to look after herself and her baby. She is home-bound, reticent about speaking English and although she knows she is in a difficult situation and has been treated badly is unsure of how to proceed. Fortunately, she is seeking support from

an agency in Vancouver (Section 4.2).

Sita (age 21), also had an arranged marriage which did not work out. She stated that her husband simply wanted her to earn money, while she wanted to pursue her education. While Sita is working full-time, attending university, and is quite happy with life in B.C., she acknowledges that she is living in Vancouver instead of Fiji because of the impact her divorce is having on her family there. She is on good terms with her family but maintains that her living in Vancouver has much to do with that. All of these factors influence how a woman comes to terms with her new "place" in the world, whether this place is defined in geographical terms of location or refers to the changing roles South Asian Fijian women are expected to fulfill through their everyday activities.

The "postmedical" geography suggested by Kearns (1993) is concerned with the relationship between an individual's place in the world and their experience of place. In light of these ideas, the inherent spatiality of social life (Dyck, 1992: 245) illuminates the health experiences of South Asian Fijian women. Women's places are intimately linked with women's roles, not only in the activity taking place, but the venue of this activity as well. Therefore, we see that women in this study carry out their roles at home, in the workplace and in the community more or less enabled and constrained by social and cultural norms, as they are socially constructed in the

context of the move from Fiji to B.C (Sections 4.1 - 4.5). A social constructionist framework has provided the basis for exploration of South Asian Fijian women's views of health in the context of the immigration experience and their everyday lives in B.C, and has provided an opportunity to explore new conceptions of health and place for immigrant women. Such an approach necessitates that attention be paid to the broader context of women's lives, and rather than simply focussing on health as disease or illness related, and considers health an inherent factor in women's abilities to perform their everyday tasks effectively, and also considers health to be fostered or constrained by these same activities. By examining the opportunities that South Asian Fijian women have for making appropriate choices which will ensure the attainment of health and well-being, one finds that broader societal factors have a strong influence (Sections 4.1 - 4.5, 5.2.2 and 5.2.4). The value and uniqueness of this case study is not its comparability to other studies, or its generalizability to the greater population, but to theoretical understandings, and most importantly, to the women who participated in the study. By actively considering the role social, cultural, and economic processes play in everyday life, one is able to consider the individual experiences of women in context, for example, as enabled or constrained by social position, cultural background, income level, or citizenship status. Further, this clarification provides the opportunity to

understand why some South Asian Fijian women are economically better off than others. For example, Verinder (age 46) is economically secure and highly educated. This is partly due to her urban background in Fiji, the economic position of her family there and to her opportunities for education and employment (Section 4.3). Kirmina (age 21) on the other hand, is from small town, has a limited education and does not have access to the support system that Verinder does. The interesting part comes when one considers the considerable cultural and social constraints that both Verinder and Kirmina experience, regardless of their economic position. Verinder remains in a marriage in order to "save face" in her social network even though she is physically and verbally abused. Kirmina is afraid to return to Fiji because of her failed marriage and also wishes to "save face" for the sake of her family who still lives there (Sections 4.2 and 4.3). One cannot simply analyze the everyday lives of these women in terms of economics, culture or social networks exclusively. The interplay of all of these factors must be considered, and the role of theory in attempting to clarify this, is helpful. While this study may not inform health policy to the extent that changes will occur that will benefit the women who participated in this study directly, the fact that women were sought to comment as experts on their own lives indicates a hopeful direction for social research in general. In this light, this study is a contribution to both the ongoing and

dynamic endeavor of developing theory and method in health geography, and attempts by the Province to engage in community based research which will inform broader outlooks on health. By considering the broader outlooks on health as expressed by the women in the study (Section 5.1), the B.C. government may be able to better link with other sectors to develop the type of health policy which recognizes that people's individual and collective visions of health are inextricably linked to their life experience (Sections 4.1 - 4.5).

6.3.2 Methodological Contributions

Qualitative research methods were useful in providing an in-depth look at women's experiences. Qualitative methods are a natural out-growth of the theoretical framework which allowed for direct involvement of South Asian Fijian women and service providers in the research process and the opportunity to consider the information provided by the participants as the expert knowledge on this subject.

Issues surrounding cross-cultural research were very important and necessitated an on-going reflexive process whereby the researcher remained aware of her position as a white outsider, and as an active player in the research, not an objective observer. Consideration of aspects of feminist theory and method in regard to cultural and ethical issues was useful, especially in light of issues surrounding reflexivity and the empowerment of research participants. By focusing on the expert knowledge provided by participants, the research

proceeded *with* participants, rather than *about* them. While it is difficult to be specific about instances of empowerment that may have occurred, at the very least women were given the opportunity to talk about their lives.

6.3.3 Substantive Issues

The health concerns of South Asian Fijian women are inseparable from their everyday life experiences in British Columbia (Section 5.3). This finding supports the objectives of this research in that the health concerns of participants were documented, and the links between perceived health status and participant's perceptions of the immigration experience were illuminated. Links between ethnicity and health in place for South Asian Fijian women were found to arise from or be embedded in life experience, which is socially constructed (Sections 4.1 - 4.6, and 5.3). There are strong links between health status and migration, particularly surrounding emotional adjustment and changes in the family. These links in turn influence the achievement of health in place. Many of the women in the study are experiencing acceptable physical well-being where they are now living, but health is also dependent on being happy and settled. In order to achieve health in place more effectively, and in some cases more efficiently, health and social policy must work together. This requires attention to the process by which social policy goals are prioritized, and to serious attempts at intersectoral collaboration. As Walters (1992: 373) states

"it may be that the roots of the problems women report lie in the social problems they identify and that they require initiatives outside the health care system". This is certainly the case for certain issues of importance to South Asian Fijian women, such as counselling for domestic violence, but this does not imply that problem areas should automatically become the entire mandate of a different department or ministry. Strategies for addressing problems would most effectively take place through cooperation and information sharing between all sectors.

6.3.4 Implications for Health Policy in British Columbia

The complicated issues of theory, method and empowerment are intimately tied to the possibilities of changing health policy in British Columbia to reflect a broader definition of health which takes into account the needs, beliefs and aspirations of all people. Both service providers and individual women provided suggestions for the policy realm, not all of which are new, but all of which are important (Table 5.1). There is some overlap in the suggestions made by individual women and service providers, especially around health care provision in the home, language services and broadening the world view of health, perhaps indicating critical areas for immediate action or further research. So far, the multicultural "rhetoric" referred to by Lock (1990) fails to recognize intraethnic diversity and tends to categorize cultures by race, colour and language. This desire

TABLE 6.1

SUGGESTIONS MADE BY PARTICIPANTS FOR IMPROVING HEALTH CARE DELIVERY TO IMMIGRANT WOMEN

INDIVIDUAL WOMEN	SERVICE PROVIDERS
HEALTH CARE DELIVERY	**HEALTH CARE DELIVERY**
•Improve language and interpretation services	•Improve language and interpretation services
•Address loneliness in older people	•Make mainstream health services more culturally sensitive
•Provide more counselling for domestic violence	•Do not separate health services for ethnic groups
	•Increase time available to service providers for patient care
	•Modify home care services to reflect the need of extended families
HEALTH POLICY	**HEALTH POLICY**
•Pay families to care for their own	•Address power politics in health policy process
•Improve refugee claimant health benefits	•Health promotion must be contextually appropriate
•Support day care in the home	•Increase flow of information between all collaborative sectors
	•Pay family members to care for family at home (British model)
DEFINITIONS OF HEALTH	**DEFINITIONS OF HEALTH**
•Rethink the clinical focus	•Consider broad health beliefs a learning process
	EDUCATION OF HEALTH PROFESSIONALS
	•Educate health professionals about cultural sensitivity
	•Foster better non-verbal as well as verbal communication skills
	MULTICULTURAL ISSUES
	•Be proactive, not reactive regarding multicultural issues
	•Deal with "white fears" and make multiculturalism understood

to neatly categorize and then generalize to cultural groups in Canada undermines individual experiences, whether positive or negative. The result manifests itself in people falling through the cracks when services do not meet their needs.

What is necessary is the development of health policy which recognizes the differences in all people and which is flexible and adaptable enough to apply to many different situations. The challenge lies in administering a more flexible, adaptable and "understanding" health care system, while developing policies that assist in making administration more universal and efficient. This may sound impossible, but as has been found in this study, those women who are accessing the health care system well will probably continue to do so, but those who are just coping and getting by in an ongoing struggle will not. The overriding finding in this study has been the tenacity, determination and strength of women facing all kinds of situations in the home and community, both in Vancouver and in Fiji. Women are strong and capable, but are not always happy. While this strength and determination is admirable, we have to ask whether or not something can be done within the confines of social policy to address health as it exhibits itself as "happiness" or however one wishes to describe this aspect of well-being. Health and happiness are summed up well by Kalbash:

> And those kind of successes, having not blown it with the children or whatever. . . to feel happy and when your mind is happy then your mind is healthy, when your mind is healthy then your body is healthy and all of those little things fall into place. And when you look at the holistic picture of women's health, sure, there may be some physical aches and pains that are happening, but it doesn't cause the same kind of anxiety because the mind is at peace and that whole thing makes a complete picture of either good health or bad, or poor health, or whatever.

6.4 Future Research

This research represents an appropriate point of departure in a long term research program in health geography. The results of this research have provided a means to discover the links between everyday life and broader social processes, in this case, the relationship between the health concerns of South Asian Fijian women and the new social and spatial environments created by migration.

There are several issues raised in this research which warrant consideration in future research, and which may be useful in informing health policy. These suggestions are as follows:

(1) The link between the emotional and physical well-being of immigrant women warrants further investigation, especially in light of role changes in the family and the multiple burden hypothesis (Verbrugge, 1983; Walters, 1992). Some studies indicate that multiple roles show no significant negative impact on women's health, or may in fact enhance it (Waldron

and Jacobs, 1989), but specific cultural, political and economic situations facing immigrant women may produce a different result, at least in the short-term. An investigation of the work that immigrant women do, and the resulting impact on health in place would contribute to knowledge in the context of a broader population health framework which concerns itself with the living and working environments that affect people's health (FTPAGPH, 1994).

(2) A comparison of immigrant women's and men's health concerns would be useful in order to investigate the role of gender in health in place, also in the context of a broader population health framework. The addition of a longitudinal component to the design of either of the above research projects would be useful to determine changes in health experiences over time, although costs in terms of both time and money are major considerations in the design of longitudinal studies (Babbie, 1992).

(4) The above research suggestions could be explored using a qualitative framework similar to that employed in this study, or could be designed as broader surveys composed of (1) a quantitative component which measures health status in terms of specific indicators, and (2) a qualitative component designed to relate individual experience to health status.

The challenge lies in the cost-effective collection of a variety of data in the face of current fiscal restraint. Ultimately, broader research approaches will provide a more

balanced view of health in place.

In regard to the theoretical framework employed in this research specifically, and the comments above, the social constructionist perspective in health research has only become more fully articulated as medical knowledge and disease categories have come to be recognized as social products themselves (Coburn and Eakin, 1993: 93). One must be wary when employing this approach not to waver toward a position of extreme relativism which denies any universal standard. This is particularly important in the health policy realm where the challenge lies in providing universal health care to several million unique individuals. Having said this, however, it is crucial for health policy makers to realize that

> Determinants of health cannot be understood apart from the fundamental issue of how health is defined and that these definitions embody, explicitly or otherwise, a social theory of what constitutes a healthy person, a healthy life or a healthy society (Coburn and Eakin, 1993: 92).

Endnotes

1. The term "South Asian has been chosen to describe the ethnic background of the women in this study. The terms Indian, Fiji-Indian, Indo-Fijian, and Fijian have also been used in the literature and everyday discourse to describe people of Indian descent living in Fiji and Canada. The term South Asian will remain consistent throughout, except where authors are quoted directly, or where another term is more significant. The meaning of being "South Asian", discussed in some detail by Buchignani et al (1985: 122) is important in that it denotes how non-South Asian Canadians may categorize people in a multicultural society. Similarly, in Fiji all white people are called "Europeans" regardless of nationality. In terms of this thesis, however, South Asian is not meant in general terms and the author would like to make it clear that the intraethnic diversity amongst people of South Asian descent may represent the greatest diversity among all ethnic groups. South Asian Fijians are just one example of this intra-ethnic diversity, both in relation to other South Asians from outside Fiji and also in relation to each other.

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APPENDIX A
CHECKLIST OF TOPICS

A. Demographic questions:

1. Name/number of participant (pseudonym) _____

2. Address _____
_____
_____

3. Telephone number _____ 4. Marital Status _____ 5. Age ____

6. Employment status/occupation _____

7. Area of Residence (urban, suburban, rural) _____

8. Annual Income (self) _____ (family) _____ 9. Household size

10. Number of children _____ 11. Generations under one roof _____

12. Years in Canada _____ 13. Birthplace in Fiji _____

14. Language proficiency _____ 15. Mode of transport most often used _____

16. Statement of own health status _____
_____
_____
_____
_____
_____
_____

Notes:

APPENDIX A
CHECKLIST OF TOPICS

B.

Health (Medical) Related Topics

1. Meaning of "health" to participant(s) (tundroosti)
2. Use of health care services (doctors, clinics etc.)
3. General state of health
4. Immediate worries
5. Chronic health problems (diabetes, breast cancer)
6. Dietary changes, exercise
7. Reproductive issues
8. Mental health issues
9. Care of the family
10. Lifestyle health risks
11. Traditional healing practices
12. Own role as receiver/provider of care
13. Any other issues raised by participant

Everyday Life

1. Family life
2. Social life and friends
3. Moving to Canada from Fiji
4. Language
5. Transportation
6. Work (type of employment, eg. physical labour, office work etc.)
7. Child care
8. Loneliness/Homesickness
9. Domestic violence
10. Any other issues raised by participant

APPENDIX B

Explanation of Research Project

THE RESEARCHER

Joan F. Gillie is a graduate student in the Department of Geography at the University of Victoria. Information derived from these interviews and focus group meetings will form the basis of a thesis required for the completion of a Master of Arts degree in Geograpy. Ms. Gillie's thesis supervisor is Dr. Susan J. Elliott, an Assistant Professor in the Department of Geography, UVIC.

GOALS OF THE RESEARCH

The research is intended to illuminate the health experiences of immigrant women in relation to new directions in health care policy in the province of British Columbia. More specifically, it will examine the experience of South Asian Fijian women, over the legal age of 19 years who reside in Greater Vancouver and the Lower Mainland, in order to discover their health concerns, their immigration experiences and their impressions and experiences of the British Columbia health care system.

RESEARCH METHODS

Interviews of a sample of individual women and community and health care workers (key informants) will be undertaken. PARTICIPATION IN THE PROJECT IS COMPLETELY VOLUNTARY. All participants will remain **anonymous**, and interviews are completely **confidential**. Participants are free to stop the interview or retract information provided during the course of the interview at any time within a three month period following the interview. Information beyond that period will be incorporated into the thesis.

FINAL REPORT

It is expected that the research will be completed and the results offered for evaluation to the researcher's thesis committee at the University of Victoria by September 1995. Provided the thesis is deemed acceptable by the committee, a copy of the thesis will be available in the MacPherson Library, University of Victoria. A summary of research findings will also be provided to Immigrant and Visible Minority Women of B.C. (IVMWBC) and Vancouver Health Department.

ENQUIRIES

If you have any further questions, or decide that you would like something added to (or deleted from) the interview record, please do not hesitate to call me, Joan Gillie, at 656-1741. If I am not available, you can leave a message for me at the Department of Geography, UVIC, at 721-7350 (between 8:30 - 4:30 p.m. weekdays).

YOUR PARTICIPATION IN THIS PROJECT IS GREATLY APPRECIATED

Funding for this research provided by the British Columbia Health Research Foundation.

अनुसंधान परियोजना का स्पष्टीकरण

अनुसंधानी

जोआन. एफ. जिली JOAN F. GILLIE विक्टोरिया विश्व-विद्यालय के भूगोल विभाग में एक स्नातक GRADUATE विद्यार्थी हैं। इस इन भेंट-वार्ताओं एवं मुख्य क्षेत्र (फ़ील्ड) समूह (फ़ोकस ग्रुप) की बैठकों में प्राप्त हुई जानकारी भूगोल में एम.ए MASTER OF ARTS स्तर की पूरा करने के लिए प्रतिज्ञा का आधार होगी। Ms. Gillie के प्रतिज्ञा प्रोफ़ेसर डाक्टर सूसन जे इलीयट DR. SUSAN J. ELLIOTT हैं जो विक्टोरिया विश्व-विद्यालय के भूगोल विभाग में सहायक प्रोफ़ेसर स्थापित हैं।

अनुसंधान के लक्ष्य

अनुसंधान का मंतव ब्रिटिश कोलंबीया प्रांत. आप्रवासी नारियों के स्वास्थ्य अनुभवों के बारे में स्वास्थ्य परिक्षण की नीती के नए आदेशों पर रोशनी डालना है। विशेष कर 19

वर्ष की कानूनी आयु से ऊपर की ~~दक्षिण~~ (व्हाण) एशीया की ५५
फीनी की नारिया जो कि ग्रेटर वैनकूवर अथवा लोयर ~~मेन~~ मेनलैंड
(सेपिधालिक)

(VANCOUVER AND LOWER MAINLAND) में इस वर्ष से अधिक नही रहे है, के अनुभवों को, उनकी स्वास्थ्य सम्भलियाओं, उनके अप्रवासिक अनुभवों एवंग उनके ब्रिटिश कोलंबीया के स्वास्थ्य परिश्रम प्राणाली के प्रभावों अथवा अनुभवों की जांच पड़ताल करना है।

अनुसंधान की विधि प्रणाली

व्यक्तिगत नारीयों एवंग समुदाय अथवा स्वास्थ्य देख रेख कार्यकर्ताओं (मुख्य सूचक) से प्रतिरूप भेंटवार्ताए की जाएंगी। परियोजना में भाग लेना बिलकुल स्वेच्छा प्रेरित (स्वेच्छा प्रेरत) है। सभी विभागी अज्ञात रहेंगे एवंग भेंटवार्ताए बिलकुल गोपनीय रहेंगी। भागीयों को छूट होगी कि वह भेंटवार्ता को एकदम स्थापित कर दे अथवा भेंटवार्ता के दौरान दी गई जानकारी को भेंटवार्ता देने के तीन सप्ताह के अंदर कभी भी वापिस ले सकते है। इस समय के

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बाद जानकारी प्रतिज्ञा में सम्मिलित कर दी जायगी।

अन्तिम प्रतिवेदन (रीपोर्ट)

यह प्रतीक्षा की जाती है कि अनुसंधान 15 अप्रैल 1995 तक पूरी करके विक्टोरिया विश्व-विद्यालय की अनुसंधानीय विवेचनार्थ समिति (थीसिस कमेटी) को मूल्यांकन के वास्ते अर्पण (अर्पण) कर दी जायगी। यदि प्रतिज्ञा समिति द्वारा स्वीकार्य मानी जायगी तो प्रतिज्ञा की एक प्रतिलिपि (कापी) विक्टोरिया विश्व-विद्यालय की मैकफर्सन लाइब्रेरी में उपलब्ध होगी। अनुसंधान के परिणामों का सारांश इनटर-कल्चरल एसोसीएशन आफ ग्रेटर विक्टोरिया I.C.A., वैनकोवर मल्टीकल्चरल सोसाईटी (V.M.S.) अथवा MOSAIC (वैनकु. को भी प्रदान की जायगी।

पूछ ताछ

यदि कोई आपके अतिरिक्त प्रश्न हो अथवा संस्थान

के विवरणों (रेकार्डों) में आप कुछ बढ़ाने या घटाने का निर्णय लें तो कृपया मुझ, JOAN GILLEY, फोन नंबर 656-1741, से बिना हिचकिचाहट के सम्पर्क करें। यदि मैं उपलब्ध न हूँ तो आप मेरे लिये विक्टोरिया विश्व-विद्यालय के भूगोल विभाग, टेलीफोन 721-7350 (8:30 और 4-30 pm weekdays) पर सन्देश छोड़ सकते हैं।

इस परियोजना में आप का सम्मिलन अति प्रशंसनीय है।

इस प्रतियोगिता के लिए धन्न राशी ब्रिटिश कोलंबीया हैल्थ रीसर्च फाऊंडेशन ने दी है।

APPENDIX C

Letter of Informed Consent

I understand that any part of my discussion with Ms. Gillie regarding the health concerns of South Asian Fijian women, their experiences of the health care system in British Columbia, and the immigration experience is intended for her use as data on which her M.A. thesis in geography is to be based. Ms. Gillie may use this material in future publications or public presentation that may follow from this research.

My participation in the project has been completely voluntary. I understand that my identity shall remain anonymous and that the interview(s) conducted between the researcher, Joan F. Gillie, and myself are completely confidential. My name will not be used: I will be assigned a pseudonym or number. I am free to withdraw from the interview/study at any time without any explanation. I will be audiotaped during all interviews. I was also given the option of participating in the study without being audiotaped with the researcher writing down my responses. All interview information in the form of tapes and documents will be stored in a locked room or cabinet and will be destroyed by Ms. Gillie after analysis is completed. Written manuscripts will be shredded and audiotapes crushed and torn apart rendering them absolutely useless. Destruction of interview material will take place after analysis is completed: by April 30, 1995. Ms. Gillie must abide by these conditions in order to use the information provided for any purpose.

I have read, and understand the explanation of the research project and discussed it with Ms. Gillie. By signing this letter I give my consent to participate in this study.

Ms. Gillie will remove from the record all or part of any information provided by me during the interview(s), providing I make this request within three months after our last interview.

_____ _____

(Participant's signature) (Date)

_____ _____

(Researcher's signature) (Date)

शोधित का स्वीकार्य पत्र

मैं यह समझता हूँ कि मेरे विनिमयों का कोई भी हिस्सा Ms Gillie द्वारा दक्षिण एशिया फिजी नारियों की स्वास्थ्य समस्याओं, उनकी ब्रिटिश कोलंबिया के स्वास्थ्य व परिश्रम नीती के अनुभवों अथवा उनके अप्रमाणिक अनुभवों के बारे में, जिसका यह Ms. Gillie अपनी भूगोल शास्त्र में M.A. करने की प्रतिज्ञा का आधार बना रही है में आंकड़े के तौर पर प्रयोग करेंगी। Ms. Gillie इस सूचित सामग्री का प्रयोग, भविष्य में प्रकाशन अथवा सार्वजनिक प्रदर्शनी, जो उनके शोध अनुसंधान से परिभाषित होगी, में कर सकती है।

मेरी सहयोगता इस प्रयोजना में बिलकुल स्वेच्छाप्रेरित है। मैं समझता हूँ कि मेरी पहचान अज्ञात रहेगी अथवा भेंट वार्ताएं जो मेरे या अनुसंधानी, Ms. Gillie, में हुई हैं बिलकुल गोपनीय रहेंगी। मेरे नाम का प्रयोग नहीं होगा। मुझे उपनाम अथवा नम्बर दिया जायगा। मुझे छूट होगी कि किसी समय भेंटवार्ता/खोज के दौरान, कोई किसी व्यवस्था

के अलावा, विकास ले सकता हूँ। मेरी
श्रव्य-पट्टी (AUDIO TAPE) की जाएंगी। मुझे यह विकल्प
भी ~~दिया~~ दिया गया है कि ~~भेंट~~ भेंट में मेरे दीये गए
उत्तर आडियोटेप न हों और अनुसंधानी उन्हें स्वयं लिख
ले। भेंटवार्ताओं में टेप अथवा लिखित प्रणाम की शक्ल में
दी गई सूचना बंद कमरे या अलमारी में रखी जायगी और
Ms GILLIE इसे विश्लेषण पूरा होने के बाद नष्ट कर देंगी
लिखित हस्तलेखों को पूरी तरह फाड़ दिया जायगा अथवा सिडियो-
टेपस को इस तरह कुचला और तोड़ा जायगा कि वह बिलकुल व्यर्थ
हो जाए। भेंटवार्ताओं की सामग्री का विश्लेषण पूरा होने
के बाद होगा, (अप्रैल 30, 1995 तक)। दी गई सूचनाओं का
करने के वास्ते Ms. GILLIE को इन शर्तों का पालन करना
जरूरी है।

मैं ने Ms. Gillie द्वारा अनुसंधान परियोजना की
व्याख्या पढ़ी है और समझी है अथवा उनसे विचार विमर्श
किया है। इस पत्र को हस्ताक्षरित करने से मैं इस परियोजना में भाग लेना
स्वीकार करता हूँ

यदि मैं भेंट वार्ताओं के बाद तीन महीनों के अंदर Ms Gillie
से विच्छेद करूं तो वह मेरी दी गई कोई सूचना अथवा उसका कोई भाग
अपने रीकार्ड से निष्कासित कर देंगी।

भाग लेने वाले के हस्ताक्षर
अनुसंधानी के हस्ताक्षर

दिनांक
दिनांक

University of Victoria

Certificate of Ethical Approval of Research Involving Human Subjects

This is to certify that the University of Victoria Ethics Review Committee on Research and Other Activities Involving Human Subjects has examined the research proposal by:

Joan F. Gillie, Graduate Student, Department of Geography

entitled: The Health Concerns of South Asian Fijian Women Living in Vancouver and the Lower Mainland

and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulation Involving Human Subjects.

Members of the Committee

Name	Position Held	Department or Discipline
Michael Corcoran, Ph.D.	Associate Dean, Research	Research Administration
Dr. J.E. Petersen	Director	University Health Services
Mr. J.M. Hutchison	Barrister & Solicitor	SMITH HUTCHISON

22 June 1994	Michael Corcoran, Associate Dean, Research	Alex McAuley, Associate Vice-President, Research
Date	Committee Chairperson	Department Head or Institutional Representative

(Ethics)

P.O. Box 1700, Victoria, B.C., Canada V8W 2Y2 Telephone (604) 721-7973, Fax (604) 721-8960

VITA

Surname: GILLIE Given Names: JOAN FRANCES

Educational Institutions Attended:

University of Victoria	1979-1981
University of the South Pacific	1990-1992

Degrees Awarded:

B.A.	University of the South Pacific	1991
Post-Graduate Diploma	University of the South Pacific	1992

Honours and Awards:

Prem Chand Prasad Prize in Geography	1991
Gold Medal in Social Science	1991
British Columbia Health Research Foundation Studentship	1993-1995
M.A. Mickelwright Prize	1994

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Title of Thesis:

A Geography of Health and Ethnicity: The Health Concerns of South Asian Fijian Women Living in Greater Vancouver British Columbia

Author

Joan Frances Gillie
September 18, 1995