Healthy living for immigrant women: a health education community outreach program

From the front lines

Aux premières lignes

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The racial, cultural, linguistic and religious diversity of Canada's population presents an important challenge for physicians and other health care providers. Increasing awareness of this diversity on the part of medical professionals is crucial to the delivery of appropriate and responsive health care. In any community, health planning, the needs of immigrants, particularly women, must be given special consideration. Newcomers to Canada often experience the personal and financial hardship of social isolation, discrimination and occupational adjustment.[1–3] Social integration for immigrant women can be a slow, difficult process impeded by cultural and linguistic barriers.[4] Often, these women are consumed by their family's needs and have very little time to attend to their own. They cope with this tension silently, often with only minimal support, and may pay little attention to their own health until a problem becomes urgent.[5,6] Many have genuine concerns about their ability to explain their symptoms to their physician and to understand the treatment that is offered.

This article describes a health education community outreach program for immigrant women in Gloucester, Ont. This consisted of a series of 3 information sessions held in May 1995 after a need was identified by a market research initiative of the Gloucester Centre for Community Resources. After publication of its report,[7] the Centre appointed a project coordinator to address the needs of multicultural groups in Gloucester, especially women. I was then invited to conduct the information sessions. Entitled "Healthy Living, Healthy You," the program had 2 main objectives: first, to identify specific health education needs and, second, to present the requested information effectively. The fact that the latter objective proved to be the most challenging aspect of the program underscored the valuable role that physicians can play in enhancing a transcultural approach to health care delivery.

The program

In May 1995 I volunteered my time to set up health education seminars for 3 consecutive weeks at the Gloucester Police Centre and Gloucester Community Centre. These locations were chosen because they were familiar and easily accessible to women in the area. Many factors were considered with a view to helping the women attend the seminars, such as time of day, child care, transportation, availability of translators (relatives or friends) and the relevance of the health topics presented. Incentives for participation included free child care and transportation, general education about women's health issues and the opportunity to form networks with other women. Participation was voluntary. The Gloucester Community Centre serves people with various ethnic backgrounds, most of whom have some skill in spoken English.

Information needs of the target population had been assessed by the project coordinator by telephone and in 2 open discussion sessions. In addition, at the first session I surveyed members of the audience with the help of translators.

In view of the linguistic diversity of the participants, the sessions were conducted

in English. They were held once weekly, the first 2 in the evening and the third in the daytime. Each session lasted 2 hours and required extensive use of audiovisual aids and of translators. An informal style was maintained to encourage participants to ask questions. Slides and an overhead projector were used to display themes and illustrations, and as the discussion progressed ample time was allowed for translation of pertinent points. Participants were also encouraged to take printed handouts about breast self-examination, contraception and nutrition, crisis support services and other community resources available for women.

The first and second daytime sessions were attended by 30 and 50 women respectively. There was an element of surprise in that some husbands attended, even though they were told that the sessions were geared toward women's issues. When questioned, the men explained that they were also interested in obtaining general health information. They were allowed to stay. The almost 100 participants who attended the third, daytime, session were all women.

The women who attended were mainly residents of the area served by the community centre. They ranged from women with young children to perimenopausal women and were from varying socioeconomic and linguistic (Chinese, Spanish, Lebanese, Somali and Arabic) backgrounds. The women were reserved at first but then spoke with greater ease as the seminars progressed, especially in the all-women daytime session. By the end of the third session the participants were glad to have initiated supportive networks and said that they would keep in touch with one another to share information. It was clear that the group dynamics were very positive, despite linguistic and cultural barriers.

The questions posed by the women in the first 2 sessions related to issues pertinent to the whole family: nutrition, how to use an emergency department at a hospital, how to use the 911 service and how to access poison control. Additional questions related to illnesses such as hypertension, heart disease and diabetes. At the third, daytime, session, several issues were discussed that had not been raised in the sessions attended by men, such as contraception and screening for breast and cervical cancer. Questions pertaining to the environment, foods, allergies and athsma were also raised. It is not unusual for women of various cultural backgrounds to speak more freely in the absence of men, especially with regard to personal issues.[1,8,9]

Lessons learned

The needs assessment conducted by the project coordinator showed that vaccination, medication and emergency services (what they are, where they are offered, what procedures are involved, etc.) were topics of interest. In the second survey the author identified these topics as well as general health issues such as nutrition and family planning, the role of physicians and of police in the community, and many others. The mode of presentation evolved as the sessions progressed. It quickly became apparent that the presentation style had to be modified to a pictorial presentation in order to bypass the linguistic roadblocks and help the audience to become more engaged. This was supplemented with a question-and-answer format that allowed the group to participate actively in the sessions and to interact with and learn from one another. The participants' questions also served as prompts that helped me to adjust the content of the sessions. What was intended to be a women's health seminar rapidly evolved into a general medical seminar.

Participants voiced their gratitude for being made aware of the community services available to them. They were quite appreciative of the fact that a medical person had come into the community to talk to them about health issues affecting themselves and their families. The expectation that a physician would explain the role of the police was surprising, but gave me an opportunity to discuss health issues in a societal context.

As the sessions progressed, the women raised questions about the role of the family physician in the community and voiced concerns about how physicians perceived them with respect to cultural and linguistic differences. Most of the women perceived that language difficulties presented an obstacle to seeing a physician. They also felt that they had to be very ill before they consulted a physician. Other concerns related to how the physician could help them with stress, tensions at home and interactions with society. Although the women did not elaborate on the nature of their stressors, there appeared to be a genuine interest in seeking out supportive counselling.

In their comments at the end of the series, participants indicated that the seminars helped to clarify how to access the health care system, when it is appropriate to see a physician and the importance of preventive measures such as vaccination, good nutrition, cervical screening and mammograms.

Conclusion

A number of factors can compromise health care delivery for immigrant women; physicians may be hampered by a lack of time and of access to translation services, and patients may be impeded by linguistic and cultural barriers. It is well documented that immigrant women use health care services far less than other women.[5] The "Healthy Living, Healthy You" project helped to address some of these barriers and demonstrated that health edu-

cation for immigrant women requires a unique communication style. Health education is essential to an effective response to the needs of immigrant women and calls for innovative approaches to communication. Remuneration mechanisms for physicians who offer this type of service to the community should be encouraged, a proposal consistent with the recommendations of the "Women in Partnership" national symposium held by Health Canada in Ottawa, in September 1994.[6] Future reforms in our health care system must take into account the needs of immigrant populations and incorporate culturally sensitive policies and programs. And, as health care services shift toward a community setting, continued efforts must be made to involve immigrant women in health promotion research to identify culturally senstitive issues.

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