

# **Toward Equitable Health and Health Services for Cambodian Refugee Women: An Ethnographic Analysis**

Final Report to the Joint Centre of Excellence for Research on Immigration and Settlement (CERIS)

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## **Abstract**

This goal of this research project was to learn about Cambodian-Canadian women's health experiences. We argue that health narratives specifically, and resettlement experiences more broadly, provide insight into this ethno-cultural group's health literacy and health seeking behaviour, as well as the barriers they experience accessing health services. Such narratives also expose the complexities of resettlement. These complexities are personal and collective, social and political, and impact upon women's health and the health of their families. Findings from this research support the women's health/community development initiative of the Canadian Cambodian Association of Ontario, as well as build upon Canadian research which explores the impact of resettlement and integration on refugee health and refugee integration within local communities.

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## Project Introduction

Cambodian refugees began arriving in Toronto in the late 1970s and early 1980s, fleeing from the violent social and political upheaval of the Khmer Rouge genocide which lasted from 1975-1979. In her study on Cambodian resettlement in Ontario, McLellan (1995) found that women who survived the Khmer Rouge genocide, refugee camp life and resettlement have suffered most, and in strikingly different ways than Khmer men. These women have had to overcome personal experiences of violence and have taken on new social and family roles as heads of their households. At the same time, many of these women are undereducated and illiterate in their own language, posing additional resettlement challenges. Despite such overwhelming social, political and cultural changes to Khmer everyday life, and specifically the everyday life of women, there has been little specific research exploring Cambodian women's experiences, changing roles and their needs (see Ledgerwood 1990; Kulig 1991), as understood through their own narratives.

In addition, research which has explored Cambodian refugee health, mental health and resettlement has almost exclusively been conducted in the United States (see Ledgerwood 1990; Kulig 1991, 1994a, 1994b; Sargent, Marcucci and Elliston 1983; White 2002; Marcucci 1986; Duncan 1987; Stevens 2001; Ong, 2003; Ebihara, Mortland and Ledgerwood 1994), calling attention to the need for Canadian-based policy-relevant research on the Cambodian community, and specifically on women. This research project, as such, explores Cambodian refugee women's resettlement experiences through health narratives and narratives of resettlement, in order to better understand how to develop culturally appropriate women's health promotion strategies within the community. Through their own narratives of health, and in particular, narratives of reproductive health, we are able to begin to recognise how Cambodian women's experiences of accessing health influence further health-decision behaviour, their health literacy, and the cultural and social barriers that they face in accessing health care services. We are also able to begin to think critically about Canadian health and social policy as it affects those amongst the most marginalized in Canada, refugee women.

The York University research team partnered with the Canadian Cambodian Association of Ontario (CCAO). The CCAO has recently begun developing a women's health portfolio recognising the need to understand the systemic, social and cultural barriers that Cambodian women face when utilising health care services in Toronto. This project is one of the first which is directed specifically at Cambodian-Canadian women's health issues. The research from this project will benefit Cambodian women and the larger community by providing **(1) women, who are the most socially isolated members in the community, the opportunity to identify their own health needs; and (2) community service providers with culturally-based evidence of health seeking behaviour.** The CCAO will use the findings from our collaborative research project to continue developing their women's health programming and policy, as well as using the evidence to procure new funding in the area of Cambodian-Canadian women's health. Of great significance to the CCAO is that this project has provided the opportunity for women to gather and share their stories, and to begin discussing ways to improve their health literacy and access to services. In addition, by collecting women's health narratives, this study documents the voices of this marginalised ethno-cultural community in Ontario.

## Literature Review

This project builds on the works of Scheper-Hughes and Lock (1987), Fox (1999), Lupton (1995), and Adelson (2000) who define 'health' as a system of knowledge and power: one that is enacted and interpreted; is historically grounded; is mediated and influenced by social, cultural, political and economical discourses; and, is "laden with ideological nuances [that] can never be separated from cultural norms and values, regardless of how the latter are played out in our

everyday lives" (Adelson 2000:3). Furthermore, this research is grounded in a framework of embodiment, arguing that the body is a socio-cultural and historical phenomenon "imbued with social meaning...historically situated, and...not only a signifier of belonging and order; but also an active forum for the expression of dissent and loss, thus, ascribing it individual agency" (Lock 1993:141; see also Scheper-Hughes and Lock 1987; Lupton 1995; Adelson 2000; Fox 1999; Csordas 1994; Ginsburg and Rapp 1991, 1995; Reischer and Koo 2004; Price and Shildrick 1993). Defining the body as such, the body becomes reframed within social theory as a site for exploring relations of power, and of individual and social reproduction (Csordas 1994; Scheper-Hughes and Lock 1987; Lock 1993; Reischer and Koo 2004; Adelson 2000; Lupton 1995; Dossetor 1996).

According to Dunn, studies have shown that research conducted within, for and by marginalised groups "serves as [a] tool for generating knowledge, building capacities and skills, and fostering social change within marginalised communities" (2004:109). This project draws upon qualitative and participatory research methods, using such forms as group discussions to access health narratives. **We argue that health narratives become a vehicle through which health needs and barriers to health can be problematized and re-negotiated, couched within the knowledge, attitudes, beliefs and practices of the participants** (Wallerstein, 1992; Williams, 2003; Steffen, 1997; Ochs & Capps, 1996).

A previous study on immigrant health status in Canada (Newbold & Danforth, 2003) illustrated that over time, immigrant health worsens relative to Canadian-born residents. Additionally, studies focusing on immigrant and refugee women's use of breast cancer screening services argued that immigrants and refugees face barriers in accessing health care services in Canada (Choudry *et al*, 1998; Meana *et al*, 1999; Bottorff *et al*, 1998; Nerad & Janczur, 2000). Such barriers include language, socio-economic status, gender, cultural difference and identity, and the stigma associated with being a newcomer to Canada. This marginalisation, according to McLellan's 1995 "Report on Cambodian resettlement in Ontario", has been exacerbated by government policies that treated Cambodians under the same settlement programmes as other groups from Southeast Asia, minimising their cultural differences. Furthermore, she argues that the settlement programmes that did exist have not been sustained within the community, helped few refugees, and have not addressed the issues of torture and war: "[the] highly respectable Centre for Victims of Torture in Toronto had not even listed [Cambodians] as a community in need, despite the fact that the majority of Cambodian men, women and older youth experienced torture and inhuman living conditions" (McLellan, 1995:12). More recent literature on refugee resettlement argues that considering the provision of health services is a useful entry point for understanding the resettlement process, as health status has conventionally been used as a measure of successful integration (Beiser 2005).

## Research Methods

### Research Site

Research was conducted within the Cambodian community living in the Greater Toronto Area (GTA). Group interviews took place within women's homes, at the Canadian Cambodian Association of Ontario (CCAO), and at the Hong Fook Mental Health Association. The research team identified the 5 key neighbourhoods within the GTA where many Cambodian families live to conduct our interviews. Women were thus invited to participate at a location most convenient to them.

### Research Ethics

This research project was approved by the York University Human Participants Review Sub-Committee (HRPC). Those who agreed to participate in our study were provided with a translated information and consent form. This consent form was read to them and they were

also provided the time to review it. We answered any questions prior to beginning our interviews.

### **Study Participants**

Out of 264 women contacted via letter, 29 participated in this study. All of the participants were born in Cambodia, in territory which had been annexed by Vietnam, or in a refugee camp. All women spoke fluent Khmer and all felt most comfortable conducting the interviews in Khmer. A majority of the women arrived as refugees in the years after the Khmer Rouge genocide. Women were between the ages of 30 – 70 years old.

### **Interviews**

A total of six group interviews and one one-on-one interview<sup>1</sup> were conducted. Using ethnographic research methods, we invited women to participate in group discussions, limiting each discussion group to no more than seven women. Our interview schedule consisted of both close-ended demographic questions and open-ended questions which considered access to health services, experiences of resettlement and integration, and the meaning of health and healthy. Using an open-ended, semi-structured interview guide format, we were able to encourage participants to speak freely, allowing associations to be made between their ideas and experiences, and the ideas and experiences of the other participants. Our group discussions were facilitated primarily in Khmer and were tape recorded for transcription purposes. After each interview, the research team debriefed and identified changes to the interview guide.

### **Data Analysis**

The ethnographic data has been analysed for thematic associations between accessing health care services in Toronto, narratives of resettlement and experience of barriers to health and well-being. The data was also used to identify meaningful aspects of being Khmer women living in Toronto. Together, this data will inform our understanding of Cambodian culture and identity, of Cambodian practices, and of ways to provide culturally appropriate health care information and services to the community.

### **Preliminary Research Findings**

We transcribed and analyzed approximately 15 hours of group interviews, the following highlights our key findings by themes:

#### **(1) Defining Health**

- Healthy is defined as free from physical and emotional illness. Being healthy means being happy. Unhealthy is when the body is “broken down” both mentally and physically.
- Participants clearly articulate that health – physical and mental - is maintained through eating fruits and vegetables, and getting enough sleep and exercise. Women also felt that feeling attractive contributed to a sense of well-being and health.
- The women felt that job security and family separation causes emotional and physical distress. In particular, the demands of factory work are stressful on their bodies. Their relationships with their husbands and their children also contributed to emotional distress. Women often complained of thinking and worrying too much about money and familial relationships.

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<sup>1</sup> The one-on-one interview took place as a result of only one participant showing up for the pre-arranged group discussion interview.

- In Cambodian culture, women do not often share their stories of suffering or their health concerns with one another, and this can lead to delays in seeking health services.
- Participants recognize the importance of their own health but also defined their health in terms of the welfare of their families, in particular their children.
- Many of the participants defined “thinking too much”, “worrying” and “going crazy” as “depression”. They linked their experiences of migration and resettlement (i.e. job and family stress) as a cause of their depression. Those who experienced depression also suffered from headaches. Some women sought medical care (e.g. via Hong Fook Mental Health Association) and were on medication. Other women developed their own strategies, such as meeting with friends, going for walks and shopping. Many felt that money would solve their depression.

## **(2) Health Care Experiences**

- On a whole, the women prefer the Canadian health care system to the Cambodian one; in Canada health care is free, offices are cleaner and they feel “greater safety” with physicians.
- Many of the women described finding their health care provider either through friends or by finding a clinic close to where they lived. Few had used resettlement or community agencies. Women also use walk-in clinics.
- Some women expressed difficulties describing their health concerns to their care providers. They often brought family members – husbands or children – to their appointments. Others felt that going alone to appointments and struggling in English helped them gain independence.
- Women also complained of the long wait in doctors’ offices and the short time they have “face-to-face” with their physicians. When doctors don’t take the time to listen to women’s concerns, they feel they are not “looking closely enough”. The lack of time physicians spent with women, made some feel they could not trust their doctor. One woman described the health care system as one lacking relationships:
 

“I don’t mind if it’s a male doctor or female doctor. I look for a doctor who can spend more time with [me] and get to know [me], but the reality is you can never find that...Nothing is perfect, but you learn to tolerate it, but I think the lack of relationship is missing. Everything is just rush, rush all the time.”
- All women have used traditional Khmer medicine (e.g. coin rubbing, skin stretching, herbal wine) at one point in time; however, the overwhelming majority of women agree that routine (western) medical examines (i.e. physicals) are vital to ensuring ones health. When asked about specific women’s health issues such as breast exams and pap tests, less than half the women confirmed they had undergone either exam regularly.
- None of the women used traditional Khmer medicine on their children; these healing practices are painful. Some women also expressed their fear about what people will think about the marks that Khmer medicine leaves on their children’s skin, and so refrain from using it.

### **(3) Resettlement and Health**

- Some women felt isolation and as a result, a lack of independence. This was due to their age, diminished physical independence, lack of language, and financial security. For one woman, she compared Canadian neighbourhoods to Cambodia. In Cambodia, she had her family and friends around. In Canada she finds it more isolated: "Everything is closed up".
- Women expressed the difficulty of sharing problems and trusting others for fear of the consequences on family reputation:

"Sometimes when I want to tell other people about my problem, I don't feel secure enough to trust them, because of the society. It's all our own family's reputation, I can't talk anything bad about them, so most of the time I just depend on myself, but it's not easy. It's too stressful."

- Women agree that the lifestyle in Canada provides more opportunities but also is much harder. They find there is little time for rest, employment is demanding and unstable, and the cost of living is high, all of which cause stress and worry.
- Many of the women expressed the difficulties of the Canadian lifestyle, which in turn makes them unhealthy:

"Here in Canada, we have to pay for the rent or mortgage, all utilities, hydro, car payment, insurance and so many bills to pay. Our mind, our brain thinking and worried so much, like it's going to explode. We all have to work both men and women, in order for us to survive living in Canada. No choices. If we want to live comfortable live, we have to work, to buy a car so you can go here and there not to depend on transportation. Buy a home, we have pay taxes. In Cambodia, we do too but very little compare to here. We work non-stop and also our thinking, we worried so much about family, money, pay bills, our children, our job, so much in our brain, so that is how I become depressed. I develop a mental problem; almost 100% of everyone from Cambodia develops this problem."

### **(4) Community Support**

- Women expressed an interest in participating in more group activities to learn of others' experiences. Group activities provide an important venue for learning and collecting information about their health.

"When I am surrounded by other people I forget those things that are in my mind. Just like today, come together as women and talking and sharing experiences, is good. It helps release the stress that I got."

- The group discussions provided the opportunity for the women to problem solve and support one another. For example, as one woman described her feelings of isolation and missing her family another woman suggested she sponsor her parents to come to Canada. When the participant confirmed her parents were coming to Canada, the other participants congratulated her.

### **Preliminary Observations**

In this section we consider some of the major themes raised through our research which requires further analysis and consideration by our research team. The preliminary research findings help



to identify the participants' health knowledge and the tools they draw upon to both access health services and to be healthy. These observations also point to the contradictions and complexities of resettlement, which impact and influence women's health and well-being.

The first major theme is how women define health. For them, to be healthy is to experience happiness and job security, *in addition* to being free from acute and chronic disease. The participants also identify family well-being as one way they measure their own wellness, indicating the importance of they place as women and as mothers on family welfare. The women are clearly able to articulate the different ways in which they are able to maintain their health and the health of the families (e.g. diet, sleep, exercise, money, etc.). What is not clear from this research, however, is how their health practices have changed since arriving in Canada, which might indicate the influence of western conceptualizations of healthy bodies have on their own constructions of what is healthy.

Tying into this theme is the use of the word "depression" by women to describe feelings of isolation, loneliness, "thinking too much" and worrying; experiences which are uniquely related to migration. As the literature reviewed here states, research has shown a link between migration and mental health. However, what is poignant to us is the consideration of the 'migration' of these women's collective experiences of suffering and distress into something that is defined biomedically and individualistically as depression. Specifically, what is the process through which women come to experience their experiences of distress and suffering as depression? Furthermore, what is the relationship between the types of resettlement services available to refugees and mental health programming and funding?

Second, the women offered personal observations of the Canadian health care system. In relation to this, "time" was a major and repeated theme. The concept of time was defined both as the amount of time spent with their providers, as well as the value of their time as a factor influencing their decision to seek medical care. In both instances, time is central to how they access and experience the health care system.

A third overarching theme speaks to the role of community agencies and community support systems can play in assisting women in dealing with the complexities of resettlement, which include accessing the health care system, and in dealing with feelings of isolation, distress and loneliness. Their narratives illustrate that while on the one hand it is culturally "inappropriate" to talk about difficulties with others, on the other, such opportunities help to alleviate stress and help women learn about their health. The contradiction inherent in these statements illustrates the difficulties community organizations experience when trying to reach out to the marginalized within their communities and yet reinforces the importance of such organizations. The Canadian Cambodian Association of Ontario has experienced acute cutbacks in government funding, which directly affects their ability to develop sustainable community programming. One area from this research for further consideration is the role that community based research can have in influencing policy and, concomitantly, funding agendas.

Finally, the women's narratives speak to the greater need to understand how to deliver health services to marginalized groups that are culturally, physically, economically, as well as gender, relevant and appropriate. The women's experiences shed light on their questions and concerns regarding their health and health care needs (e.g. breast health and pelvic exams) as well as their uncertainty of how to obtain more information, illustrating areas for future research. Specifically, questions such as how have resettlement programs assisted refugee women in obtaining health and social services; how can culturally-specific community-based agencies influence the health policy agenda; and what role can informal social networks play in supporting women's needs, which cannot be answered by this pilot study, are but a few possible directions for future research.

## **Research Dissemination**

All members of our research team (i.e. York University and the Canadian Cambodian Association of Ontario [CCAO]) have copies of all research materials and transcribed interviews. The CCAO may use this final report and any publications that follow to develop their women's health/community development initiatives. The CCAO will be invited to co-present and co-publish our research findings. In addition, our community-based researcher provided two women's health workshops in the fall of 2006 to women in the community on reproductive and breast health. These workshops have been one way in which the team has begun to use the information collected in the study to promote the health and wellness of the community.

This final report, along and any publications, will be provided to other community stakeholders (e.g. the Hong Fook Mental Health Association and the Jane and Finch Family and Community Centre), as well as the members of parliament for the regions where the Cambodian community is primarily situated. The research team will also disseminate our findings to other Cambodian communities across Canada. The CCAO may choose to use this report and our extensive findings to procure additional women's health and community development funding. Our graduate research student will be encouraged to present findings at local and international conferences.

Finally, the narratives presented here are testaments to the every day lives of refugee women and their families. They provide important insight into the diverse landscape of Toronto communities and are valuable evidence for health policy decision-makers. Ethnographic research such as this study, offer theoretical and empirical knowledge which both challenge and expand what can be considered health services. As the women themselves argued, social gatherings provide a necessary and important opportunity for education and healing. Furthermore, as our health-based workshops illustrated, social gatherings are an excellent opportunity to create, mobilize and transfer knowledge, both health knowledge as well as knowledge on social integration. This research project provides new evidence for inclusion into the health services policy landscape – indeed into what counts as “health services”: it is grounded in the lived experiences of the very women Canadian health and social services ought to serve.

## **Additional Information**

### **York University Research Team**

The principal investigator of the research project, Professor Naomi Adelson, Chair of the Department of Anthropology at York University, oversaw the implementation of all research strategies and the analysis of data. The project hired a Master of Arts graduate student, Ms. Beth Dewitt, who is currently completing her thesis research exploring issues of identity and cultural change of Cambodian-Canadian women through their narratives on pregnancy and birth.

### **Community Partnership**

The York University research team collaborated with the Canadian Cambodian Association of Ontario (CCAO) to develop the research strategy, conduct interviews, and review the research findings. Through the CCAO, York University hired a Cambodian woman, Mrs. Nathalie Kheo, active in the community as the team's community-based research assistant. Nathalie organized our research communications and interview sessions, provided translation during interviews and transcription of the recorded material. Nathalie also facilitated our health information sessions in the Fall of 2006. Through our relationship with the CCAO, and because of the years of dedicated community work of our community-based research assistant, York University gained access to Cambodian women within the community.

### **Training Opportunities**

This project required the assistance of a Master of Arts student. We hired Ms. Beth Dewitt, who is currently completing her graduate research within the Cambodian community. Her knowledge of the community and her relationships with community members was a strong resource for our project. In addition, Ms. Dewitt is currently enrolled in the Ontario Training Institute's Health Services and Policy Research graduate diploma, requiring her to complete both a health policy and health research practicum. Her assistance on this project will provide her with the health services and policy research training she requires for her diploma programme. She assisted in all aspects of this research project, including the design of interview questions, an extensive literature review, and the implementation of our interviews, and the analysis of our findings. This position gave her hands-on training in both qualitative research design and policy/programming reporting. Beth also trained our community-based research assistant, Nathalie, in ethnographic research methodology.

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