

Accessing Primary Care in Canada: Giving Voice to the Perceptions and Experiences of Racialized Immigrants (A Systematic Review)

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INTRODUCTION

In Canada, immigrant health is becoming a more popular and valued area of study among major research funders such as the Public Health Agency of Canada (PHAC), Canadian Institutes for Health Research (CIHR), and Metropolis.

Canadian immigrants are visible minorities

Over the last decade, Canada's population growth can be primarily attributed to immigrants and, in 2006, approximately 20% of Canadians were immigrants (Chui, 2007). Over the last 25 years, more than 70% of immigrants have been identified as visible minorities, and, in recent years, approximately 50% have come from Asia. (Statistics Canada, 2008). Statistics Canada (n.d.) defines visible minorities as persons who are non-Caucasian in race or non-white in colour.

Research on immigrants and health

Immigrants access health care at different rates and in different ways from Canadian-born persons (Kinnon, 1999). In Ontario, for example, new immigrants are less likely to receive an annual check-up and/or have a family doctor (Chu, 2008). This variability in health care access has been suggested to be due to: challenges in finding culturally-sensitive services, priority of other settlement issues, and differences in expectations and perceived need of health care services. A popular area of research has been the 'healthy immigrant effect,' which states that immigrants' health status is quite good upon arrival to Canada, but tends to deteriorate over time (Hyman, 2007; Newbold & Danforth, 2003).

Despite the increasing ethno-cultural diversity of Canadian immigrants, there is an identified gap in academic research on how race, culture, and ethnicity intersect to affect immigrants' health status and health service utilization (alPHa, 2003; Chu, 2008; Khanlou, 2006; Kinnon, 1999). Much of the existing knowledge is based on reports from health-care providers or standardized government surveys (e.g., Canadian Community Health Survey), or has been generated from non-profit and/or community-based organizations (e.g., Access Alliance Multicultural and Community Health Services, Wellesley Institute).

From static to dynamic: visible minorities as racialized groups

As a term, 'visible minorities' is "static and relates primarily to number and colour" (Access Alliance, n.d.). However, since ethnicity/culture/race are recognized as social determinants of health – especially when they are connected with social exclusion, discrimination, and marginalization (Galabuzi, 2006; PHAC-B, n.d., Wilkinson & Marmot, 2003) – a more appropriate term that recognizes the impact of this ongoing experience is *racialization*.

Racialization is a dynamic, socially constructed process of categorization that leads to systemic social, economic, and political inequality and differential treatment; racialization can be based on race, ethnicity, language, religion, culture and a host of other associated characteristics (Galabuzi, 2001; University of Guelph, n.d.; Access Alliance, n.d.).

Focus of this systematic review

The focus of this systematic review are the perceptions and experiences of racialized immigrants in accessing primary care in Canada as recorded/reported through the voices of immigrants. Health Canada's website (www.hc-sc.gc.ca) defines primary care as "the element within primary health care that focuses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury" (n.d., n.p.) We narrowed our definition of primary

care to the first point of face-to-face contact with Canada's traditional model of health care services. More detail about our inclusion/exclusion criteria can be found in the Methods section.

Through scoping and personal/anecdotal experience, we held several assumptions about the outcomes of this review, including expectations of qualitative research as the predominant methodology, studies with a range of racialized groups, and perceptions and experiences of cultural insensitivity in primary care as a recurring finding.

Guiding principles

As reflexive researchers, we believe we would be remiss to justify our research topic purely on literature, without explicitly acknowledging the influential role of our epistemological and personal perspectives.

We recognize the relevance of our identities as academic researchers and members of racialized Canadian immigrant families to this topic. Additionally, we locate ourselves in social constructionist/health promotion paradigms. Social constructionism acknowledges people's reality as based on their experience of the world versus a reality that claims to be empirically defined (Patton, 2002); and so, immigrants' experiences/perceptions are reflected through the social construction of immigrants, the migration process, racialization, and primary care. This aligns with our health promotion principles, based in the Ottawa Charter for Health Promotion (World Health Organization (WHO), 1986), which states that "...health services must be refocused on the total needs of the individual whole person" (p. 3). Health promotion embraces equity, social justice, empowerment, and community participation as core values.

It is noteworthy to mention that, although we have stated our assumptions and epistemological principles, we embrace systematic review as a process for reducing, challenging, and managing bias in the retrieval and review of literature (Petticrew & Roberts, 2006). We maintained complete integrity by following the standardized steps of systematic review that are presented in the methods section.

Objective

To systematically review academic literature about the perceptions and experiences of racialized immigrants in accessing primary care in Canada, through the voice of immigrants.

METHODS

Before starting this systematic review, a protocol was devised for our search strategy, inclusion and exclusion criteria, data extraction, and quality appraisal.

Search strategy

Full details of the search strategy can be found in Appendix A.

Searches were conducted from October to November 2008 and the following electronic databases were employed: Scholars Portal Social Science Database, MEDLINE and CINAHL. Search terms were tailored for each database to ensure a comprehensive and inclusive search (e.g., in Scholar's Portal, immigrant or newcomer or migrant). Truncation and Boolean operators were used extensively.

A scoping review revealed it would be difficult to term ‘primary care’ and ‘racialization’ in ways that could be applied to database search functions, so, after initial database filtering, we hand-searched abstracts for these criteria. Studies were included if, in the case of primary care, they referred to face-to-face contact with care/services provided by family physicians, nurse practitioners, community health centres, walk-in clinics or primary mental and sexual health services or for preventative health care traditionally delivered in a family physician setting (e.g., pap screening). Searching for racialized immigrants was accomplished by checking the study sample against the Statistics Canada (n.d.) definition of visible minorities.

Generally, the following inclusion/exclusion criteria were applied to databases:

Inclusion criteria:

- Canada
- Racialized immigrants (see above)
- English language publications, dated January 1998 to November 2008
- Primary care (see above)
- Voice: data that was generated from immigrants themselves
- Perceptions/experiences, including beliefs, attitudes, and expectations about accessing primary care

Exclusion criteria:

- Only examined specialized care/services, alternative care/medicines, pharmacy or, tele-health services,
- Acute care (e.g. hospital).
- No voice of immigrants (e.g. only data from health care providers or academia)
- Only examined refugees
- Ambiguous definition of immigrants or primary/health care
- Grey literature and non-peer reviewed literature

The choice of publication dates was based on limited time and resources. Grey literature was excluded because we were especially interested in looking at peer-reviewed academic literature, based on the identified gap discussed in the introduction. Additional search methods, such as reference list searching or internet searching (Popay et al., 2006) were not employed for this review.

Study Selection

At first, articles were filtered in the databases by applying search terms to keywords, and then to abstracts. Selection by hand-searching began after this filtering was completed, for which we used RefWorks, a web-based bibliography and database manager, to organize retrieved articles.

Initially, 161 articles were uploaded to RefWorks. Of these, 34 duplicates were removed, 97 excluded after abstract review, and 19 excluded after article review. Eleven (11) articles were retained for final analysis. Appendix B features a visual depiction of this process.

During the first stage of selection, three reviewers performed independent inclusion/exclusion assessments of abstracts for the first 16 of 161 articles. . Assessment results were only shared after all reviewers established their ratings. Any disagreements were resolved through discussion, and in the case of ambiguity, articles were retained for full review. After this initial assessment, it was necessary to “elaborate on the key components of the review question so as to aid [the] process of

identifying studies to include in the review” (Popay et al., 2006, p. 9) and ensure that future decisions were consistent. During the second stage of selection, the remaining 145 abstracts were divided among the three reviewers, who then independently applied inclusion/exclusion criteria for assessment based on abstracts.

During the last stage of selection, remaining papers were re-sorted (to improve randomization) and divided among the three reviewers, who then independently applied inclusion/exclusion criteria for final assessment based on the full text of the article. Again, in cases of uncertainty, articles were discussed among reviewers, and then a unanimous decision for inclusion or exclusion was made.

Data Extraction

We designed a MSExcel matrix to facilitate the process of data extraction (See Table 1). Studies included for final analysis were divided among the three reviewers, and study characteristics (e.g., participant characteristics, research aim, methodology, findings) were independently extracted. To identify the presence of “natural groups” or “clusters” of studies with similar characteristics (Popay et al, 2006, p. 27), two reviewers examined the completed matrix. The first reviewer examined study findings exclusively, while the second reviewer reviewed all remaining characteristics.

Quality Appraisal

Quality appraisal was informed by a checklist developed by England’s National Critical Appraisal Skills Programme (CASP) (Public Health Resource Unit, 2006). Although this checklist was intended for assessing qualitative research studies, modifications were made when necessary to reflect study methodology (e.g. “Is the qualitative methodology appropriate?” modified to “Is the methodology appropriate?”). Only articles kept for final analysis (i.e. those found in Table 1) were included for quality appraisal and a separate MSExcel matrix (available upon request) was used to input these results.

Synthesis

We used a narrative synthesis approach to best elicit the common themes that emerged from the findings. To organize themes, a single reviewer used a “concept mapping” approach (Popay et al, 2006, p. 20). This required a process of colour coding and regrouping of studies with similar findings.

RESULTS

Data extraction

Results of data extraction are presented in Table 1.

All 11 articles examined a range of immigrants’ perceptions and/or experiences of access to primary care in Canada. Three were based in the Greater Toronto Area (GTA), two in Calgary, two in Vancouver/Richmond and an unspecified city in British Columbia, one in Edmonton, one in St. John’s, one in an unspecified Canadian city and one based upon seven Canadian cities. All articles were published from 2001 and onwards, with four published in 2007. Five articles employed a qualitative research design, five employed a quantitative research design (e.g. surveys with likert-type ratings) and only one employed a mixed methods approach. All studies included adult participants (i.e., 18+), five had female immigrants exclusively, six included female and male immigrants. None examined male immigrants exclusively. Five studies investigated Chinese immigrants, two studied Iranian immigrants, two studied South Asian immigrants, one studied Vietnamese immigrants and

one studied Muslim immigrants. Seven studies dealt with issues related to family physicians, three articles examined women's preventative health issues (e.g. pap screening or clinical breast examinations), and one examined issues related to prenatal / post natal care.

Quality Appraisal

All studies provided a clear description of their research aims and findings. Ten studies clearly articulated and linked their research design to the research question, while three failed to justify their choice of research design. Nine studies employed appropriate methodology, selection and recruitment strategies, but often failed to mention reasons for participant withdrawal. Seven studies showed some consideration regarding researcher-participant relations; two discussed researchers' social location and personal connection to the research; while five employed language and cultural sensitivity in their design. Nine studies explicitly stated that they obtained ethical approval but a lesser number, described detailed ethical considerations. There were inconsistencies in rigour across studies, as inferred by varying degrees of member checking, inter-rater coding processes and the quantity of data to support findings. Contradictory data was rarely used and there was little to no indication that a critical approach was taken by researchers to examine their own role and potential biases. All studies contributed to a knowledge base of predictors or understandings associated with immigrants' health seeking behavior, and most provided recommendations for future research, service planning or health interventions.

Narrative Synthesis

The voiced perceptions and experiences of racialized immigrants in Canada seeking primary care were overwhelmingly negative, with a few exceptions. The findings have been organized into barriers and facilitators to primary care. The voices of specific racialized groups are occasionally highlighted to explicitly demonstrate overlapping themes rather than differences across findings.

Barriers to Primary Care

Experiences of poor patient-provider communication were often cited when immigrants had limited English skills (Dastjerdi, 2006; Donnelly & McKellin, 2007; Lai & Chau, 2007; Reitmanova & Gustafson, 2008). Iranian immigrants experienced negative treatment on the basis of having an accent and/or language barrier and expressed a sense of marginalization when an untrained or non-professional interpreter was used because communication then shifted away from the patient and became a dialogue between physician and interpreter (Dastjerdi, 2006).

Perceptions and experiences of physicians being too busy to listen or converse were also common across immigrant groups (Maticka-Tyndale, Shirpak, & Chinichian, 2007; Reitmanova & Gustafson, 2008; Zhang & Verhoef, 2002). Immigrants felt doctors lacked empathy or interest in listening to their feelings, concerns, or explanations of their health/illness (Reitmanova, 2008; Zhang, 2002; Maticka-Tyndale, 2007; Lee, Rodin, Devins, & Weiss, 2001). Immigrants felt uncomfortable asking questions and experienced poor referral to specialized care or community supports/resources (Liu, So, & Quan, 2007; Reitmanova & Gustafson, 2008). Access to primary care was also felt to be compromised for South East Asian and South Asian immigrant women based on a lack of awareness as well as limited/no information from providers about what preventive medical tests were standard in Canada (e.g. clinical breast examination), what these tests consisted of, and/or where to seek out such services (Ahmad & Stewart, 2004; Donnelly & McKellin, 2007).

In general, immigrants' experiences and construction of health care from their country of origin provided the context within which their perceptions and expectations of Canadian primary care were

formed. As such, lack of familiarity with the Canadian model of primary care often resulted in general dissatisfaction with care (Donnelly & McKellin, 2007; Liu, So, & Quan, 2007; Zhang & Verhoef, 2002). Within this context, dissatisfaction arose from experiences of: long wait times to get an appointment (Dastjerdi, 2006; Lai & Chau, 2007; Maticka-Tyndale et al., 2007), having restrictions imposed on number of questions per visit (Maticka-Tyndale et al., 2007), short provider-patient time during appointment (Liu et al., 2007). There was also frustration with having to get a physician referral in order to access a specialist (Dastjerdi, 2006; Maticka-Tyndale et al., 2007). Chinese immigrants expressed skepticism about physicians' competencies and experience; they felt physicians were excessively dependent on diagnostic tools, were often unable to provide a treatment/cure, and were indifferent and dismissive of their needs (Lee et al., 2001; Liu et al., 2007; Zhang & Verhoef, 2002).

Immigrants also expressed frustration with physicians' lack of awareness or willingness to provide culturally sensitive care. Chinese immigrants resented providers' unawareness of Chinese cultural constructions of the body, traditional Chinese Medicine, and how these intersected with Canadian primary care as part of a larger illness management strategy (Lee et al., 2001; Liu et al., 2007; Zhang & Verhoef, 2002). Likewise, Muslim immigrant women indicated that providers were not conscious of how religion influenced their prenatal practices (Reitmanova & Gustafson, 2008). Cultural values of modesty, shyness, and tendencies towards pride and not asking questions made it embarrassing and uncomfortable for Iranian women to seek preventive care, like Pap tests (Dastjerdi, 2006; Maticka-Tyndale et al., 2007).

Iranian immigrants expressed that having limited/no financial and/or child-care supports were barriers to accessing primary care, such as having to defer physician visits (Dastjerdi, 2006). As well, being in the early first phases of settlement in Canada was characterized by a sense of feeling disoriented and helpless, with health care access overshadowed by other issues such as employment.

Facilitators of Primary Care

Having access to free, technologically-advanced health care was viewed favourably by Vietnamese immigrant women and some Chinese immigrants (Donnelly & McKellin, 2007; Lee et al., 2001). Medical technology was believed to be helpful in ruling out major illness (Donnelly & McKellin, 2007; Lee et al., 2001). Some Iranian immigrants did not necessarily wish to have an Iranian doctor; also, some perceived physicians who shared the experience of immigration as more empathetic than Canadian-born physicians (Dastjerdi, 2006).

South Asian immigrant women preferred having a female family physician for exams involving private body parts (e.g. gynecological exam) (Ahmad et al., 2002). This preference was associated with a higher frequency of physician visits and female doctors were characterized as typically having more positive social skills than male counter-parts. Chinese immigrant women who had female doctors had enhanced knowledge of cervical cancer risk factors (Hislop et al., 2004).

DISCUSSION

Our review revealed several limitations, opportunities for new research and implications for practice. As part of our reflective process, these limitations and opportunities were discussed and are summarized in the following sections.

Limitations

While there is a proliferation of studies on immigrant health in Canada (Hyman, 2007), few look at perceptions and experiences of racialized immigrants with primary care. No study met all of our expectations and a number of gap areas were identified. Our review may have yielded more studies if we had expanded our search terms to include concepts such as health-seeking behaviour or health practices, if we had had more time and resources, and if we had hand-searched reference lists. We recognize these constraints as limitations of our review.

The limitations presented below relate to the findings of this review and identify gaps in research.

Single Populations

With the exception of Reitmanova & Gustafson (2008), studies examined either homogenous populations or presented comparative analyses with White and/or Canadian-born populations. Specific South Asian and South-East Asian immigrant populations (e.g., Chinese) were the focus of most of the studies, which is consistent with recent immigration patterns. Other racialized groups were not at all represented in these studies, and no study examined the common experience of being a racialized immigrant across ethnic groups. Such studies would be helpful in the transferability or generalizability of findings across a broader range of racialized immigrant groups.

Study Designs

The quantitative studies were limited in their capacity to provide a complete understanding of perceptions and experiences. Use of survey tools with pre-determined answer choices limited the capacity of immigrants to have voice. A mixed methodologies approach could have enhanced findings by providing information-rich data related to perceptions and experiences (Green & Thorogood, 2004).

Most of the qualitative studies did provide rich data, but failed to note any researcher reflexivity. Reflexivity is an important, yet often neglected component of qualitative research (Finlay, 2002). Research assumptions, rationale for sampling techniques, and the epistemological principles of the researchers were seldom discussed or provided.

Narrow Study Focus

Limited data was available about the perceptions and experiences of men, teens, children and seniors. Also, the studies that focused exclusively on women only addressed gynecological and breast health, but did not shed light on other primary health care issues of importance to women, such as perceptions and experiences of care provided to their children or other aspects of primary care (e.g., heart health).

Limited Critical Social Approach

We expected to encounter findings on cultural insensitivity and how this construct may have contributed to experiences of accessing primary health care. Overall, constructs and experiences of cultural insensitivity, discrimination, or marginalization were poorly explored in the reported interview and survey questions; likewise, these constructs were seldom elaborated upon or addressed in the literature's discussions. The terms 'racialized' or 'racialization' were never used to describe the experiences of the immigrants and interpretation of findings rarely included any discourse about systemic issues or anti-oppression frameworks when recommendations were made. This insight spearheaded an animated discussion among the reviewers about why such analysis was largely excluded. We hypothesized that this may be a reflection of subconscious conceptual frameworks

among researchers that regard everyone as equal (i.e., researchers may lack awareness or may refute the existence of inequalities based on racialization); challenges in soliciting such information from research participants; and a Canadian socio-political climate of discomfort with race and racialization as constructs (e.g., in Canada, collecting race-based statistics is frowned upon) (Galabuzi, 2006).

Opportunities

During our interpretative discussions, we identified several opportunities for research and practice directions. Our individual experiences as racialized immigrants and health promotion practitioners helped us to challenge findings and our conclusions. For example, individual capacities like “becoming self-sufficient” (Dastjerdi, 2006) were discussed in relation to social context and social construction of migration, settlement, success, health, illness, and access to care.

Research Recommendations

Given the previously discussed limitations, we recommend increases in mixed methodology research that explores the perceptions and experiences of accessing primary care through the voice of racialized immigrant women, men, children and seniors, across a culturally diverse range of racialized immigrants, and in a mix of settings (e.g., urban, mid-size and rural). In addition, we recommend exploring the perceptions and experiences over a broader range of primary health care services (e.g., for men, the parallel of Pap tests/clinical breast exams could be prostate exams). It would also be beneficial to explore primary health reform and the comparative experiences of receiving care through settings other than the traditional doctors’ office model that commonly service racialized immigrants, such as Community Health Centres, Family Health Teams (in Ontario), and walk-in clinics (Chu, 2008). These research directions are supported in the recent work of Hyman (2007). Additionally, since mental health issues are often cited as an area of concern for immigrants (Beiser, 2005; Hyman, 2007), we suggest more focused research on the elements of mental health care that are provided within the context of primary care.

Providers and patients sometimes have different interpretations and understandings of a shared experience of the provider-patient relationship/encounter. We recommend an increase in research that focuses on the perspective (i.e., voice) of racialized immigrants to complement the many studies conducted from the perspective of providers. This systematic review stresses the importance of questioning assumptions made by health care providers (e.g., Do immigrants always prefer a provider from the same ethnic group? Does using interpreters always result in positive outcomes?). Dastjerdi’s (2006) findings indicated these assumptions are not always true.

We also strongly believe that a combined social constructionist/critical social approach is imperative to conducting research in this area in order to understand how processes of marginalization, sexism, racism, ableism, and heterosexism contribute to the experiences of primary care by racialized immigrants. Newcomer agencies and settlement services may be further ahead in their conceptualizations and implementation of anti-oppression frameworks; hence, we suggest funding bodies encourage more collaborative research with such agencies to ensure grounding in critical frameworks. In his own critical analysis of immigrant health research, Beiser states that challenging the socio-political paradigms within which research is conducted is imperative to avoid the oversimplification of complex issues that have characterized previous Canadian research on immigrant health (Beiser, 2005). In any case, researchers should be explicit in laying out the epistemological/theoretical lens that inform their work.

Practical Recommendations for providers

We generated a number of training competencies for health care providers based on our research findings. Suggestions included training in: i) understanding the migration and settlement experience, ii) the cultural context of health beliefs and health-seeking behaviour iii) patient use of traditional medicine, iv) client-centred care, v) using interpreters effectively and respectfully, and vi) understanding social location and power dynamics in patient-provider relationships.

Other recommendations included developing and promoting links to community services (e.g., the Ontario Breast Screening Program, for women without female physicians).

Reflecting on systematic review process

We made considerable efforts throughout our work to reflect on our experiences with the review process. Our communication tools for discussion and knowledge-sharing were face-to-face meetings, regular teleconferences and email updates. The strength of the systematic review was that it provided a clear system for searching, including, reviewing and appraising articles. The inter-rater reliability approach to inclusion of articles also helped to establish a degree of rigour and facilitated the use of a consensus model to make decisions about inclusion/exclusion, prioritize key findings and interpret findings.

Our main challenge was investigator fatigue, a result of the intense experience of reviewing and making decisions about articles under very tight timelines. We would recommend further refinements in order to simplify the narrative synthesis process that is recommended by Popay et al (2006).

The systematic review process is applauded for its standardized approach to retrieving evidence. The recording and reporting of each step in the process has great merit; however, we believe it is important to recognize that this process can never be value-free or completely objective. Subjectivity and values are reflected throughout the review, in search terms, quality appraisal, data extraction, synthesis and interpretation. There are also limitations on the reproducibility of systematic reviews. Changes to database search engines may yield different results with the same search terms due to changes in indexing. Technical glitches can also influence the quality of retrieval. Based on the above-mentioned comments, we conclude by recommending that individual reflexivity and (researcher) group reflection be included as a formal part of the systematic review process to allow a place/space for acknowledging, managing, and noting the challenges of systematic review.

CONCLUSION

The focus of our systematic review was to use a transparent process to locate and synthesize research that gave voice to the perceptions and experiences of racialized immigrants in accessing primary care in Canada. Projections indicate that racialized immigrants will continue to fuel Canada's population growth (CBC, 2008). This review reveals that there is yet a great deal to be learned about how race, culture, and ethnicity intersect to affect immigrants' health services utilization. Social constructionist and critical social science paradigms are the best suited approaches for this kind of work.

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APPENDIX A: Database Search Strategies

1. Scholars Portal

A: Keywords search field

Search Query #1

immigra* OR newcomers OR migrants
AND canad* (anywhere)
AND health

Limits: 1998 to Present
English Only

Results: 1766 Published Works results found in Social Sciences Subject Area

Search Query #2

immigra* OR newcomers OR migrants
AND canad* (anywhere)
AND health care OR health care utilization OR health services

Limits: 1998 to Present
English Only

Results: 572 Published Works results found in Social Sciences Subject Area

Search Query #3

immigra* OR newcomers OR migrants
AND canad* (anywhere)
AND health care OR health care utilization OR health services
AND perce* OR belie* OR experienc*

Limits: 1998 to Present
English Only

Results: 284 Published Works results found in Social Sciences Subject Area

B: Abstracts search field

Search Query #4

immigra* OR newcomers OR migrants
AND canad*
AND health care OR health care utilization OR health services
AND perce* OR belie* OR experienc*

Limits: 1998 to Present
English Only

Results: 131 Published Works results found in Social Sciences Subject Area

Other attempted search queries

We also tried combining these terms with other indexed terms such as: practitioner patient relationship; (primary care or primary health care); health care access; (cross cultural treatment or cultural competence or cultural sensitivity)

The results were very poor and the terms we used seemed to yield the best results.

Example:

Search Query #1 (Keywords search field)

immigra* OR newcomers OR migrants
AND canad* (anywhere)
AND practitioner patient relationship

Limits: 1998 to Present
English Only

Results: 3 Published Works results found in Social Sciences Subject Area

Search Query #2 (Abstracts search field)

immigra* OR newcomers OR migrants
AND canad* (anywhere)
AND practitioner patient relationship

Limits: 1998 to Present
English Only

Results: 0 Published Works results found in Social Sciences Subject Area

2. MEDLINE

Three search queries were conducted to obtain relevant articles. The OVID-MEDLINE collection database began in 1996, so we did not limit search by date; with the exception of the third search.

MeSH subject headings used were:

- Primary Health Care
- Immigrants
- Culture (term used for beliefs)

Search Query #1

immigr\$ AND primary health care AND Canad\$

Result: 8 articles

Search Query #2

immigrant AND health AND Canada AND barriers

Result: 18 articles

Search Query #3

immigrants AND Canada AND culture

Limits: English language
1998-Present

Result: 2 articles

Total = 28 articles

3. CINAHL

Note: A single CINAHL search was conducted and informed by the terms used in the MEDLINE search as outlined above.

Search Query #1

immigrants AND primary health care AND Canada

Limits: English only
 1998-Present

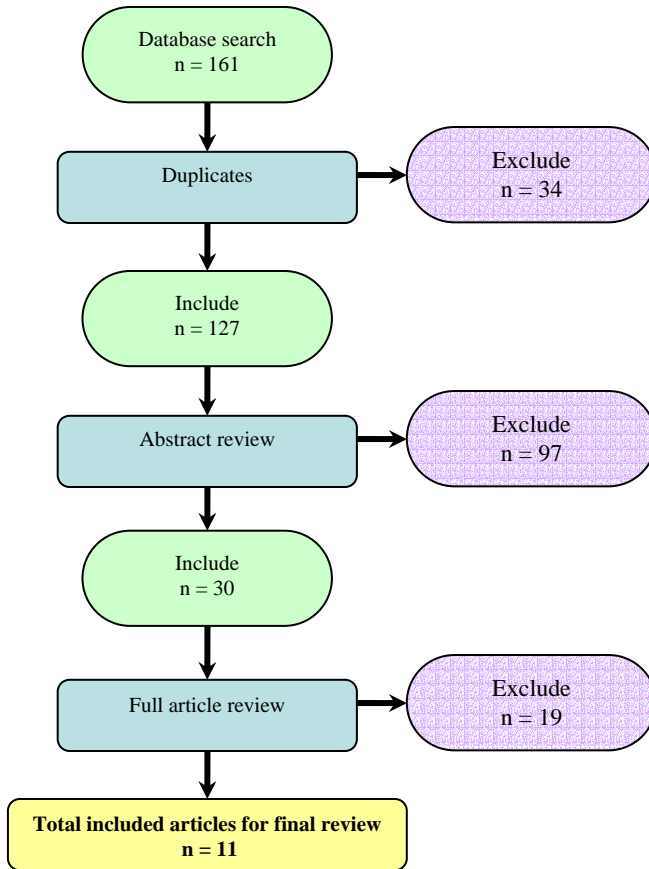
Result: 2 articles

TOTAL articles retrieved from electronic databases:

131 Scholars Portal
 28 MEDLINE
 2 CINAHL

161 = n

APPENDIX B: Search Process and Results



<u>Reasons for Exclusion n = 19</u>	
- Focus on health/illness, not health care	4
- Ambiguous use of terms (health care, Western medicine, professional help)	3
- Specialist or other non-primary care	3
- Focused only on traditional medicine	2
- Not available in print or electronically	2
- Unspecified/inappropriate population	2
- Professional/academic perspective	1
- Dissertation (used published article version instead)	1
- Focus on access to community resources,	1

Table 1. Characteristics of Included Studies

Study	Research Aim & Location in Canada	Context of Primary Care	Participant Characteristics ¹	Method	Findings
Ahmad, Gupta, Rawlins & Stewart (2002)	To investigate expressed preferences for family physician among Canadian European-descent and South-Asian immigrant women Greater Toronto Area, Ontario (ON)	Preference for family physicians	South Asian n = 44 sex = F	QN (Self-admin. survey)	<ol style="list-style-type: none"> Two-thirds of Canadian-European decent (CED) and Canadian South Asian (CSA) women had no gender preference regarding general ailments or life-threatening conditions Preference for a female family physician (FP) was expressed when involving gynecological examinations or involving private body parts For emotional and family problems 50% of the women preferred a female FP or had no preference No sig. difference between groups' preferences for overall health care Overall CED and CSA women show similar FP gender preference, but factors associated with these preferences (e.g. employment, self-perceived social support, etc) show some differences between groups
Ahmad & Stewart (2004)	To determine predictors of clinical breast examination among South Asian immigrant women Toronto, ON	Women's preventative health (CBE)	South Asian n = 52 sex = F	QN (Self-admin. survey)	<ol style="list-style-type: none"> Top perceived barriers for G-0 women (never had a clinical breast examination (CBE)) were: do not know where to go, do not understand how CBE is done, and do not know who to ask The odds of "ever had" a CBE increased with age and decreased with more perceived barriers
Dastjerdi (2006)	To identify the processes by which Iranian immigrants learn to access health care services in Canada using the Becoming Self-Sufficient (BSP) continuum Edmonton, Alberta (AB)	Family physician care and access to primary care	Iranian n = 17 sex = MF	QL (Un-structured & semi-structured interviews)	<ol style="list-style-type: none"> Access to Canadian health care services depends on where immigrants are on the BSP continuum which consists of 5 stages: (1) becoming a stranger (2) feeling helpless, (3) navigating/seeking info (4) employing strategies and (5) becoming integrated & self-sufficient Most barriers were experienced in stages 1-3 while stages 4-5 were characterized by overcoming barriers & becoming self-sufficient Accessing health care is not a priority in stage 1, settlement issues; fear of being deported if sick; surprise at wait-times & practical issues (e.g. lack of child care resulting in deferral of physician visits) would take priority. Stage 2: lack of understanding of healthcare system, negative treatment due to accent & language barriers, use of interpreters leading to feelings of marginalization, financial limitations (e.g. no taxi fare, cost of medication.), expectations of communication with physicians like back home, cultural tendency towards pride and not asking for help prevented them from asking questions during doctors visits. Stage 3: actively seeking care: having an Iranian physician was not always satisfactory, immigrant physicians were perceived as more empathetic

Study	Research Aim & Location in Canada	Context of Primary Care	Participant Characteristics ¹	Method	Findings
Donnelly, Tam Truong, McKellin & William (2007)	To investigate Vietnamese Canadian women's experiences of breast cancer and cervical cancer screening Unknown city, British Columbia (BC)	Women's preventative health (pap and breast cancer screening)	Vietnamese n = 15 sex = F	QL (In-depth interviews)	<ol style="list-style-type: none"> 1. Feelings about health care (HC) is relative to their experience in Vietnam 2. Canadian HC is perceived as 'good' because of its universal coverage (i.e. free) and its modern medical technology 3. Some believed that health and, in particular pap screening, was the woman's responsibility, including follow-up, but some also felt it was the physician's responsibility to "remind" patients of check-ups and to motivate patients (i.e. joint responsibility) 5. Lack of information, especially due to language barriers, and awareness about available services functioned as a barrier to HC
Hislop, The, Lai, Ralston, Shu, & Taylor (2004)	To address the relationship between knowledge about cervical cancer risk factors and pap screening practices Vancouver & Richmond, BC	Women's preventative health (pap screening)	Chinese n = 528 sex = F	QN (Survey interviews)	<ol style="list-style-type: none"> 1. Women who had female physicians had higher knowledge of cervical cancer risk factors 2. Respondents with highest knowledge/educational level had greater odds of ever receiving a pap test, as compared to those respondents with the lowest knowledge, and had greater odds of having received a pap test within the previous two years
Zhang & Verhoef (2002)	To generate a theory or model regarding illness management among Chinese immigrants living with arthritis & to assess factors impacting these strategies Calgary, AB	Family physician care	Chinese n = 19 sex = MF	QL (In-depth interviews)	<ol style="list-style-type: none"> 1. Seeking care from a physician was an illness management strategy used after self-care strategies had failed 2. Chinese immigrants perceive Canadian physicians to be excessively dependent on diagnostic tools and to lack necessary clinical experience 3. Chinese immigrants have negative feelings towards physicians who exhibit an indifferent manner (i.e. do not pay attention to their experiences/explanations) 4. Chinese medicine was used when Western medicine was not effective

Study	Research Aim & Location in Canada	Context of Primary Care	Participant Characteristics ¹	Method	Findings
Lai & Chau (2007)	To identify the nature and predictors of health service barriers faced by older Chinese immigrants in Canada 7 Canadian cities	Family physician care	Chinese n = 2, 214 sex = MF	QN (Structured questionnaire).	<ol style="list-style-type: none"> 1. The highest reported barriers included: language, long waiting lists, not knowing about existing health services, lack of specialized programs for Chinese, professionals lacking Chinese cultural awareness, and professionals who were not Chinese (ranked in this order). 2. When these were loaded into "factors", 4 factors accounted for over 50% of the variance: i) administrative problems, ii) cultural incompatibility, iii) personal attitudes and iv) circumstantial challenges 3. Predictors of increased service barriers included: being female, single, from Hong Kong, less years lived in Canada, less financially secure, lack of a personal confidant, identifying more strongly with Chinese health beliefs & considering oneself as Chinese or Chinese-Canadian.
Lee, Rodin, Devins & Weiss (2001)	To examine patterns of distress (namely, clinical symptoms and their social contexts), self-perceived stigma, perceived causes of illness, and various aspects of prior help-seeking Toronto, ON	Family physician care	Chinese n = 50 sex = MF	MM (Semi-structured interviews, and QN categorical coding of patients' responses)	<ol style="list-style-type: none"> 1. Despite consulting with family physicians due to OHIP coverage, there was a belief that family doctors would not be able to help 2. Preferred need to be assessed with Western medical technology to rule out major illness 3. Patient dissatisfaction was reflected when no concrete diagnosis or medication was given (i.e. feeling cheating), when they felt that too much blood was taken, or when they felt their concerns were not adequately heard 4. There was increased resentment with more blood tests, since patients reconciled that even small blood samples would drain their yang (positive energy) and further weaken their body 5. Many felt disturbed by physicians' failure to address and provide care for "distress" as a factor imposed by patients' illness (e.g. working hard to earn wages in jobs that provided health benefits contributed to distress) 6. Patients believed that referrals to mental health services reflected the family doctors' inability to attribute a physical cause to their illness. 7. Many were frustrated when their doctor did not understand Traditional Chinese medical terminology, which they used to explain their symptoms 8. Some believed only doctors were qualified to classify their illness

Study	Research Aim & Location in Canada	Context of Primary Care	Participant Characteristics ¹	Method	Findings
Liu; So; & Quan (2007)	To explore the what the satisfaction, compliance and perception of physicians among Chinese and Whites in a Canadian city Calgary, AB	Family physician care	Chinese n = 746 sex = MF	QN (Survey)	<ol style="list-style-type: none"> 1. A lower proportion of Chinese reported very satisfied or satisfied with GP care (73.7% vs. 92.8%) 2. Chinese were less likely to report that physicians had adequate experience, and that physicians spent enough time with them, and that they felt comfortable asking questions or that physicians listened to them 3. Non-English speaking Chinese & more recent arrivals in Canada were less likely to be satisfied with GPs than Chinese born in Canada 4. Recent arrivals also reported lower ratings for perceived clinical experience, adequate time spent and clarity of communication
Maticka-Tyndale, Shirpak & Chinichian (2007)	To explore the concerns, needs and experiences of Iranian immigrants in obtaining sexual health and education services in Canada Mid-sized Canadian city	Family physician care & sexual health	Iranian n = 20 sex = MF	QL (Semi-structured interviews)	<ol style="list-style-type: none"> 1. The majority of participants preferred to talk to physicians about sexual health issues 2. Regardless of years lived in Canada, long wait times needed for appointments, the requirement of referrals to access specialists, the rule of many physicians to allow only 1-2 questions per visit and the perception that they were too busy to talk to patients, deterred immigrants from approaching physicians with their concerns. 3. Modesty, embarrassment and shyness even with same-sex physician kept participants from consulting physicians (e.g. pap test avoidance)
Reitmanova & Gustafson (2008)	To explore maternity health care needs and barriers to accessing maternity health services St. John's, Newfoundland, NF	Prenatal / post natal care	Muslim n = 6 sex = F	QL (Semi-structured interviews)	<ol style="list-style-type: none"> 1. Lack of information provided by physicians about pregnancy issues, community resources/referrals, the process of labor & delivery, pain management, post-discharge information (e.g. obtaining rest). 2. Perception that prenatal check-ups were not useful 4. Perception that physicians were too busy to focus on women's feelings 5. Language barriers 6. Service providers were unaware of religions' possible influence on prenatal care needs

MF = mixed participants (female and male)

F = female

M = male

QL = Qualitative Method

QN = Quantitative Method

MM = Mixed Method

¹ Characteristics of relevant participants exclusively