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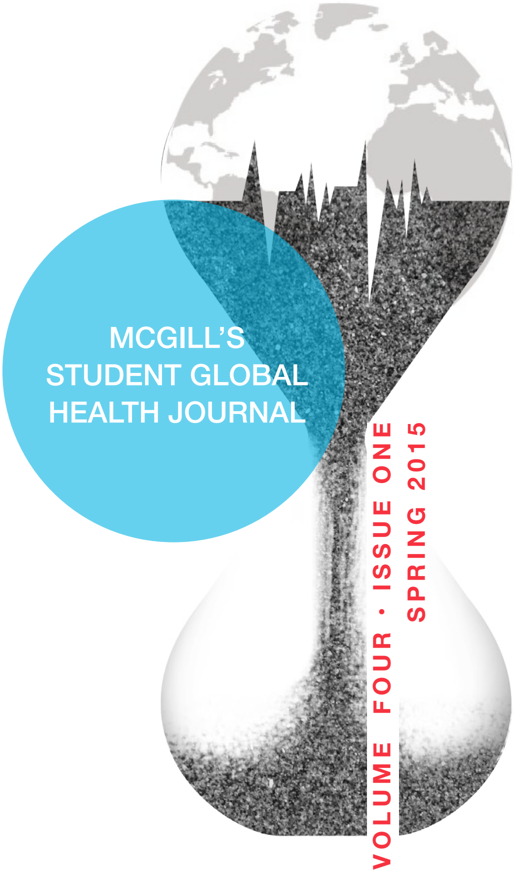

MCGILL'S
STUDENT GLOBAL
HEALTH JOURNAL

VOLUME FOUR · ISSUE ONE
SPRING 2015

The Prognosis | Spring 2015

Volume 4, Issue 1

Special Thanks :
Denise Maines
Kristin Hendricks

Cover: Tamsin Bussières

Correspondence may be sent to theprognosis@gmail.com

ISSN 1929-1620

http://theprognosismcgill.com/

McGill Global Health Programs

IHSP Institute for Health and Social Policy

The Prognosis is supported by McGill's Global Health Programs (GHP) and the Institute for Health and Social Policy (IHSP). In keeping with the journal's focus on research at the intersection of social, biomedical, global, and local perspectives on health, these organizations are uniquely placed to support the ongoing work of this student-run publication.

GHP currently partners with numerous departments at McGill to promote human well-being, productivity and economic development, and is actively involved in research and training around the globe. Committed to collaborative projects that improve health through educational, clinical, developmental and research programs, McGill Global Health Programs is excited about new avenues to enrich the education of students interested in global health. The IHSP conducts interdisciplinary research on how social conditions impact health and welfare. In particular it aims to translate research findings in the areas of social inequalities and health outcomes into concrete provincial, national and international policies. With expertise in student training, the IHSP is keen to develop additional opportunities to spread research findings that improve population level wellbeing.

From the Editor-in-Chief

Dear reader,

I am excited to present to you the fourth volume of The Prognosis. Founded in 2011 by a group of undergraduate students at McGill University, our aim is to publish the best student research in the field of global health. As befits a journal concerned with a multi-disciplinary field of research, we take a broad view of what is covered by our publishing mandate. We welcome any paper concerning any issue at the intersection of biomedical, social, local and global perspectives of health, irrespective of discipline, the only selection criteria being the quality of the research.

This volume contains six outstanding pieces of student research. From refugees' access to healthcare in Canada and Australia to the dietary structure of Inuit communities, the papers contained in this issue span the breadth of the field of global health. Our authors come from a variety of academic backgrounds, from anthropology to kinesiology. These articles reflect not only students' diverse research interests, but also the vitality of global health as a discipline among the next generation of researchers.

This issue marks many firsts for The Prognosis. It is the first to have solicited submissions from universities across Canada and the first to use peer reviewers to assess the quality of the submissions. Most importantly, this issue is the first to have been published in collaboration with McGill's Global Health Program and the Institute for Health and Social Policy. The result of talks initiated Julien Gagnon, my predecessor, this collaboration between the journal, the IHSP and the GHP guarantees continuous funding, support, and institutional continuity for The Prognosis.

I wish to thank Denise Maines of the IHSP and Kristin Hendricks of the GHP for their unfailing support of the venture, and of all the advice they provided, which has been crucial to the publication's success. In addition, I would like to thank the faculty members who have helped us by reviewing the submissions, as well as the authors who have entrusted to us their manuscripts. Finally, I would like to thank our editors, who have given their precious time and effort to make this volume of The Prognosis a reality.

Yuan Yi Zhu
Editor-in-Chief

TABLE OF CONTENTS

OCCUPATIONAL THERAPY INTERNATIONAL FIELDWORK

Exploration of Student Perceptions and Implications for Planning

Erin A. Douglas I
McGill University, Montreal, Canada
Virginie Tousignant I
Royal Victoria Hospital, Montreal, Canada
Maria Harewood I
Private rehabilitation clinic, Montreal, Canada
Caroline Storr I
School of Physical and Occupational Therapy,
McGill University, Montreal, Canada
Matthew Hunt I
School of Physical and Occupational Therapy,
McGill University, Montreal, Canada

Abstract

Increasing numbers of Canadian occupational therapy (OT) students participate in fieldwork in low and middle-income countries during professional training. There are a few studies investigating the perceived benefits and challenges of international fieldwork (IFW).

The aim of this study was to better understand the learning experiences during international fieldwork from students' perspectives.

11 practicing occupational therapists who had completed an IFW experience as a part of their required professional education were interviewed, and data were analyzed using an interpretive description methodology. Collectively, participants had completed their OT training at four Canadian universities and undertaken IFW in eight different countries.

Four themes were identified: living in a new cultural context; learning about different approaches and contexts of occupational therapy practice; supports and resources for carrying out IFW; and perceptions of how IFW affects students, clients, institutions, and host communities.

The findings of this study can inform the best practice preparation and planning for IFW by students, university programs, and host institutions so that learning and sustainability can be optimized.

This study was conducted with a small group of participants. More research is needed on the perspectives of partners in IFW from a sustainability and resource viewpoint. Moreover, a comparison of different student debriefing strategies would be useful in informing best practices.

There is a growing trend in health care professional training in many countries to expand teaching about global health issues and develop opportunities for international fieldwork for students (IFW; Barker, Kinsella, & Bossers, 2010, Drynan, 2013). These developments are also taking place in occupational therapy (OT) programs. As the role of OT in the field of global health expands, more students from high-income countries are participating in IFW in low- and middle-income countries (Barker, et al., 2010). Researchers have begun to investigate the impacts of participating in IFW for health care students (e.g. nursing; Lee, 2004, physiotherapy; Crawford et al., 2010, medicine; Petrosoniak, McCarthy, & Varpio, 2010), but there are still relatively few studies specifically investigating the perceived benefits and challenges for OT students (Barker, et al., 2010; Kinsella, Bossers, & Ferreira, 2008; Humbert, Burket, Deveney, & Kennedy, 2012). IFW provides the opportunity to experience different models of health care, gain an appreciation for culturally-informed understandings and practices related to health and rehabilitation, and acquire a better understanding of the impact of globalization on these issues. (Whiteford & McAllister, 2007; Champin, 2008; Broberg et al., 2003).

Benefits and challenges of IFW

Researchers in nursing, physiotherapy, social work, and medicine have provided emerging evidence of positive outcomes of IFW (Clampin, 2008; Barker et al., 2010; Crawford et al., 2010). These experiences are associated with the development of coping skills, adaptive thinking, cognitive development, and the ability to think critically about professional issues (Cameron, Bednar, and Valade, 2003; Standeven, 1998; Frisch, 1990). Crawford et al. (2010) examined the experiences of Canadian physical therapy students who undertook IFW. They reported positive learning opportunities, the chance to experience a different health care delivery system, and the development of enhanced cultural competence. These findings support earlier empirical research in which participants reported becoming more culturally sensitive and aware of other cultural contexts (Lee, 2004). Alappat et al. (2007) also noted that furthering training opportunities for therapists within other cultural contexts in entry-level education could greatly improve the transfer of knowledge, adaptive skills, and awareness of global health issues.

A range of challenges associated with IFW has also been described in the literature. Some challenges relate to planning and preparation such as site selection, paperwork completion, and availability of funding (Crawford et al., 2010; Reisch, 2011). Other administrative challenges, including availability and timing of fieldwork within their curriculum, and procedural issues, such as insurance and immunizations, were reported (Kinsella et al., 2008; Crawford et al., 2010). Crawford et al (2010) and Reisch (2011) describe challenges during IFW related to adapting to cultural differences, experiences of culture shock, adapting to local practices and health care systems, and situations of widespread poverty. Students may also encounter language barriers, requiring a translator or alternate methods of communication in order to communicate with patients (Whiteford & McAllister, 2007). Crawford et al. (2010) also reported that students felt the need for additional follow up and debriefing from their home institutions after the completion of their IFW experiences.

Experiences specific to occupational therapy

Commentators such as Champin (2008) and Barker et al. (2010) have argued that OT programs should integrate further opportunities for students to learn about global issues. As well as learning about global health in classroom settings, many OT students already participate in IFWs. Several research teams have conducted empirical studies to examine IFW in OT from diverse perspectives. Simonelis, Njelesani, Novak, Kuzma, and Cameron (2011) explored the experiences of supervisors, on-site staff, and OT students on IFW programs. They highlighted three themes: collaborative learning, cultural negotiations, and self-reliance. IFW program benefits included opportunities to learn collaboratively and build verbal and non-verbal communication skills (Simonelis et al., 2011). Humbert et al. (2012) conducted a study of culture and cultural learning within IFWs based on interviews with OT students. Their findings emphasize the dynamic and relational nature of IFW and identify these experiences as potential sources of increased cultural awareness and flexibility, leading to a broader worldview for students (Humbert et al., 2012). These studies make important contributions to better understand IFW for OT students. Nevertheless, there remains uncertainty about the range of benefits and challenges associated with IFW from student perspectives. We thus undertook a qualitative study to explore the perceptions of Canadian OT students regarding the benefits and challenges of having conducted IFW in a low- or middle-income country and how they perceived the longer term effects of these experiences.

Methods

Research design

Given the experiential and exploratory nature of this inquiry, a qualitative design based on an interpretive description methodology was employed (Berg, 1989; Thorne, 2008). Interpretive description takes into consideration variability as well as patterns and commonalities between individuals, and has been used effectively in smaller scale qualitative studies (Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne, Reimer, Kirkham, & O'Flynn-Magee, 2004).

Participant recruitment

A purposive sampling strategy was used to recruit a diverse set of participants. Sampling dimensions included: university in Canada where participants received their professional OT training; current area of professional practice; country and region in which the IFW took place; and 1-5 years of practice experience since graduation. Participants were recruited by email invitations through referral from the Association of Canadian Occupational Therapy University Programs (ACOTUP), the Committee on University Fieldwork Education (CUFE), the Global Health Initiative (GHI), and investigator contacts.

Participants

Participants were English- or French-speaking licensed occupational therapists that had completed IFW within the last 5 years in a low- or middle-income country (as defined by the World Bank, 2011) during their Master's level professional training. 11 occupational therapists participated in the study, and they had received their OT degree at four Canadian universities (the number of participants drawn from each university ranged from 1 to 5). Collectively, the participants completed their IFW in the following countries: Bolivia, Columbia, Kenya, Mali, Philippines, South Africa, St. Vincent and the Grenadines, and Thailand. The participants completed their IFW in the following areas of practice: community rehabilitation, mental health, orthopedics, pediatrics, and physical medicine.

Interviews

In-depth, one-to-one, semi-structured interviews (lasting approximately 40-60 minutes) were conducted with each participant following a semi-structured interview guide. Interviews were audio recorded and then transcribed. Interviews were either conducted in person or over Skype. Field notes were written following each interview.

Data Analysis

Analysis of the transcripts began as each interview was completed, with two members of the research team conducting initial coding of each transcript. Constant comparative techniques were used to compare within and between transcripts. All team members reviewed and contributed to refining the coding structure. The second level of analysis focused on the relationships between codes and involved the aggregation of codes into categories. Themes were then developed, communicating the core elements of the analysis.

Ethical Considerations

The study was reviewed and approved by the Institutional Review Board of the Faculty of Medicine of McGill University. All participants signed an informed consent form.

Results

Four main themes were developed: living in a new cultural context; learning about different approaches and contexts of OT practice; supports and resources for carrying out an IFW; and perceptions of how IFW affect students, clients, institutions, and host communities. Selected verbatim quotations are included to illustrate the four themes.

Living in a new cultural context

Participants described the cross-cultural nature of their IFW as both rewarding and a source of challenges. Most participants related specific encounters and experiences that offered opportunities to engage with and learn about cultural values, practices, and worldviews in their IFW

setting. Such experiences were described as leading to greater awareness of and sensitivity towards local cultures. For example, a participant reflected on the community-oriented values that she encountered during her IFW:
"…since then it really made me realize how much community is important and not just the immediate family but getting everyone implicated in the… form of groups … it made me realize the importance of the whole network or social network and how important that can be for anyone really…" (P5)

In describing the cross-cultural dimensions of their IFW, participants discussed factors that facilitated their learning and integration within these cultural settings, such as preparatory activities that they had completed individually or in groups prior to the IFW, as well as connections that they could draw between their own cultural background and the host culture, which some participants reported as helping them better understand these perspectives. Along with these stories of cultural learning and engagement, participants also shared experiences and offered reflections about how the cross-cultural aspect of their IFW challenged them and was sometimes frustrating or unsettling. A participant reported her struggle to understand local expectations and practices regarding the use of limited healthcare resources, and she related these to the differences in cultural values:
"I can see why [locals] want to put more resources into someone who has a very, very minor disability as opposed to a more severe disability, but that's the culture saying that we want to normalize, we want to be normal and making, labeling a child as mentally retarded just because they can't speak. That's the culture." (P8)

The participant went on to describe the struggle she felt between respecting what she saw as the local perspective and advocating for her client. Other participants reported experiences where particular cultural perspectives prompted them to reflect on some of their own assumptions and values.

Another facet of living in a different country and cultural context were communication barriers that were experienced by several participants. Such barriers had implications for clinical practices as well as for developing relationships with clients, co-workers, and others in the community. A participant described limitations related to her lack of knowledge of local languages:
"Of course there's some things that I would have liked to do with the patients, but I couldn't because of the language barrier, and some assessments that I would have liked to try but I couldn't… That was really limiting." (P6)
Several participants reported that various individuals provided translation depending on the context. They also sought creative approaches to address communication:
"We painted murals on the side of the schools with all the kids. So that was our like break-in, sort of get to know the kids, get them to know us. It was like 'play' was the sort of the translator, you didn't need language. You could just play with the kids to get them to trust you." (P4)
Creative approaches enabled participants to

make connections cross-culturally despite language barriers.

Experiences related to cultural learning, including experiences that were viewed as troubling and challenging, were described as crucial aspects of IFW by participants and also important learning opportunities.

Learning about different approaches and contexts of occupational therapy practice

A common goal among participants for taking a part in IFW was to learn about their chosen profession within another healthcare environment. In describing their experiences during IFW, participants frequently noted similarities and differences between OT practice in Canada and in the host country. Differences in practice elements, such as charting, evaluations, and treatment modalities, were identified, as well as practice values, beliefs, working conditions, and the life experiences of patients. Roles of health care professionals were also discussed by participants in terms of differences in values and perceptions within the work setting, including relations between different professional groups. For example, a participant reported that occupational therapists in the IFW setting had less professional autonomy than in Canada. She reported that a major difference was how "the hierarchy is very pronounced in [country]. The doctors decided, and we just do." (P6)

Faced with different role definitions, working styles, and resources, participants reported that they had to develop skills such as being flexible, creative, and adaptable. They also gained knowledge and skills related to treating a different set of clinical conditions and needed to account for the different realities for clients in terms of their activities, occupations, home environments, and social contexts. Participants associated these experiences with improved clinical reasoning due to the necessity of taking into account a wide range of factors and moving beyond some of the "taken-for-granted" nature of clinical practice in their home communities. According to one participant,

"the biggest sort of educational component for us was that it challenged our clinical reasoning beyond any of my other placements that I had…" (P7).

IFW allowed participants to learn about the role of OT practice in another healthcare system and develop transferable skills and attitudes that they viewed as beneficial for their future practice.

Supports and resources for carrying out IFW

Participants experienced challenges and aids related to available resources and supports. Supports included assistance from their university to prepare for their IFW, such as planning and developing communication channels with the host institution, orientation sessions, and developing a detailed placement organizational plan. Some institutions assisted the participants to find a location to complete their IFW by providing participants with a list of destinations where students from the university had previously completed IFW or supported them in finding a partner in a new country. Other participants reported that their institutions did not provide support in finding a location, leaving them to find and coordinate with a prospective site on their own. In addition to the organization of the details of the practicum, other aspects of preparation included legal requirements, travel arrangements, health insurance, and orientation to the local context once they arrived in the IFW site.

During their IFW, several participants emphasized that mutually supportive relationships with other students, local professionals, and their OT educators were key sources of support. The importance of these relationships is reported by a participant in relation to ongoing supports in the IFW setting:

"…we had a lot of support … and they were really eager to have us there. In the morning we'd all get together …we would debrief from our last time and we'd make our plans for what would come up the rest of the [rotation] but also we'd make our daily plans everyday almost like our long-term and short-term goals." (P9)

In contrast, several participants found that the support from the educator or administration at the host institution was limited. A lack of feeling supported by the local partner represented an important challenge for these participants.

Participants also reported challenges related to the availability of materials and clinical resources such as assessments, equipment, books, and articles, which contrasted with availability in their home nations. A participant reported that "[t]he resources were very limited, we often found that we had to adapt whatever we could to the kids that we were treating." (P8) Participants reported that the lack of resources challenged them to adapt and apply previously learned clinical skills to match the new realities encountered during their IFW.

Many of the participants highlighted the richness of the social resources and community connectedness in host communities, seeing these as resources that also supported their IFW experiences. A participant described the social supports that existed in her IFW setting:

"In terms of people resources, there is this huge community spirit and everybody is helping each other and the staff is very devoted to the children and the adults there. They [have] a lot of volunteers as well just to help them." (P5)

Overall, the participants associated the availability of supports in preparing and carrying out their IFW as playing a key role in the degree of success of their IFW.

Perceptions of how IFW affects students, clients, institutions, and host communities

Participants described a range of ways that they had benefited from IFW. They also reflected on whether their IFW affected clients, institutions, and members of host communities. P8 reported that the presence of international students was a source of "pride for them, kind of to see us there… They were really happy, and it gave them a little bit of hope." Several participants described the opportunity to exchange information and experiences with clients, preceptors, and other health professionals as a more tangible benefit of their IFW. However, other participants felt that they had not made a contribution to the local community, institution or patients. One participant stated,

"Well, it might be pessimistic, but I think I had almost no impact at all, because I was there only 5 weeks, and they have a type of living that's really different from here." (P1)

Several participants reported wishing that it was possible to create and manage a sustainable project within the host institution as part of their IFW. Obstacles to doing so were reported in relation to the student role

"…but you need to be contributing to something that is already established, because otherwise it's not sustainable, so that's sort of, so the other responsibilities, I guess, was to set up systems that could be sustainable." (P4)

Such feelings also led many participants to discuss struggles and potential recommendations for institutions on how they could improve IFW, clinical sites, and institutional programs. Some examples identified that would contribute to enhancing IFW included better pre-departure preparation and planning by the university, and longer duration of the IFW experience. Participants discussed the short length of their IFW, with time ranging from five to eight weeks. One participant expressed that "I think that any international placement should be 12 weeks at least…" (P7). She asserted that longer IFW would greatly enhance learning opportunities. Participants also recommended that students taking part in IFW in the future ought to have enhanced language learning, more support for financial planning, and increased advanced preparation such as learning about the local cultural and social context. Participants also emphasized the attitudes that students need for a successful IFW that would be beneficial for the students themselves, as well as clients and local communities. According to a participant, future students need to be flexible and open-minded about the differences they will encounter on their IFW:

"make sure you're open, make sure you're flexible, and [that] you don't go in [with any prejudices]." (P4)

The importance of the attitudes of the students embarking on IFW was highlighted alongside suggestions of how best to organize or implement the learning experience.

Participants discussed how participating in their IFW has impacted their future plans. A participant reported that her IFW experience "has given me the interest to go work internationally, eventually" (P10). Another participant reflected on how the IFW influenced her career goals:

"I would like to eventually teach and maybe like teach courses in community development, to work on that level. [IFW has] provided me with the hands on experience of what I would like to keep on doing professionally." (P4)

Other participants made comparisons with how the IFW helped them for clinical practice in

Canada:
"Sometimes you see different cultures in the home, so it has helped me to adapt to you know what you have, to what you have in the home. And here it's really multicultural…it helped me in this way." (P2)
In these ways, the experiences and learning that participants acquired during their IFW were seen as influencing their professional plans and future clinical practices.

Discussion

The present study highlights how the process of living in another country and experiencing fieldwork provides opportunities for personal development and learning about OT within another cultural context. Participants shared stories that described their international experiences as rich in learning, not only about themselves, but also about what their chosen profession meant within this new context. These stories also connected how practicing as an OT student in a different cultural context could create situations where they were required to use critical thinking, creativity, and problem solving in order to effectively treat a client. Participants were also confronted, sometimes to their surprise, by different approaches to healthcare and different expectations and conceptions of health, illness, community, and disability. Some participants discussed how they struggled to understand and accept healthcare norms and systems created within a different set of cultural traditions, beliefs, and values. In these ways, IFW prompted several of the participants to critically reflect on aspects of how they understood their chosen profession, their own worldview, and familiar models of care provision.

Benefits and challenges to participants on IFW

The benefits of IFW as reported by participants in this study were consistent with those reported in the literature. Personal growth, development of professional skills, and clinical reasoning were among the top benefits highlighted. Participants felt that they gained a deeper understanding of clinical reasoning than they did during their Canadian fieldwork courses. Enhanced learning may have been fostered by the confidence-building experiences of situations that required more independent thinking and flexibility (Simonelis et al., 2011).

Other benefits included increased appreciation and awareness of cultural contexts, with participants reportedly gaining a more developed sensitivity towards other cultural perspectives regarding health, illness, disability, and wellbeing. Other authors have also reported that cultural immersion of students on IFW led to critical assessment of personal skills and an increase in awareness of values and beliefs that shape other systems of healthcare delivery, particularly within OT practices (Horton, 2009; Odawara, 2005).

Challenges faced by participants ranged from culture shock to language barriers, and also encompassed administrative and organizational difficulties. Such struggles of adaptation are also reported for other health care trainees on IFW

(Crawford et al., 2010). One aspect of IFW that is particularly highlighted by the current research is how the student learning experience was also influenced by the model of teaching. Many students reported distant supervision from an off-site OT, sometimes back in their home country, or relying heavily on their local preceptor for language support.

Administrative and institutional challenges were experienced by many participants, with students facing responsibilities such as planning and organizing the entire practicum, struggling to find suitable accommodations and local transportation, and acquiring sufficient personal funding. Many reported that the associated costs prevented them making the most of their opportunity to explore and learn about the region or country in which they conducted their IFW.

Influence of IFW on students' future career

The study also aimed to explore students' perceptions of how their IFW experience influenced their own career trajectory. Participants were directly asked if participation in IFW was linked to their career goals. However, the majority of information related to this question came from other seemingly unrelated questions, where participants discussed their increased confidence, independence, and problem solving skills, as highly influential in their chosen area of work, such as private practice or in resource poor settings. The perception of personal growth as a direct result of the experience has, by definition, a longer-term impact on professional and personal competencies. Of note, our sample was restricted to practicing OTs with less than 5 years of experience, which may not be enough time for participants to reflect upon their career aspirations. If clinicians with greater experience had been sought, a greater number of participants may have had the opportunity to conduct international work. In addition, while some participants reported that they were inspired to continue international work or to work in underserved areas of Canada, the current study did not formally assess or explore the extent of these desires. Further research into the development of career goals for OT students and the influence of participating in IFW on these goals is needed.

Recommendations for students and institutions for future IFW

The study findings suggest avenues for improving IFW. Many participants stated that they felt unprepared for the cultural differences when they arrived in their host countries for their IFW. From these experiences and the expressed desire for more extensive advance preparation, several steps seem promising. Students should proactively learn about the host culture, language, and healthcare system before embarking on IFW. This preparation should include research on local values and customs, health policy and healthcare models, and traditional medicine, amongst other topics. As well, many students mentioned pragmatic difficulties when arriving in their host country. Some of these issues might be minimized with better pre-travel planning, discussions with past students, and more interaction with community contacts and institutions prior to departure.

The majority of students stated that they were individually responsible for choosing the location for their IFW and initiating contact with host institutions. This proved to be a large barrier for some students, with delayed paperwork, lack of supervision, and safety and pragmatic concerns. Given the importance of these challenges, it seems reasonable to suggest that institutions wishing to optimize IFW experiences should seek to collaborate more closely with host communities to organize a structured program or only permit students to go to locations where this is possible. Students' IFW experiences will also be enhanced with careful attention to the establishment of learning objectives and sustainable student projects prior to departure, and having a tentative schedule set for formal updates. In order to address language barriers and improve cross-cultural learning, institutions could also require that students have a minimum proficiency in the host language, as well as provide enhanced cultural education training.

The development of sustained and robust fieldwork programs in low- and middle-income countries may contribute to the further development of local rehabilitation capacity through knowledge transfer and resource building (Whiteford & McAllister, 2007). However, both institutions and students must be aware of the disparities between the settings. Attention to equity and justice concerns should prompt students and institutions to avoid treating the host setting as an educational "commodity." This arises where students are sent to learn and immediately leave (Whiteford & McAllister, 2007), creating a drain on local resources for the benefit of students from more affluent countries but providing little or no local benefit (Elit et al, 2011). Greater institutional investment in creating sustainable training and service programs that include reciprocity of learning opportunities and exchange of knowledge would help to address these concerns. An important step towards these goals would be to partner more closely with host institutions so that they are an integral part of the planning process and thereby contributing to viable sustainability.

There are a number of limitations to the present study. It was conducted with a small group of Canadian occupational therapists. Though participants came from four universities, the purposive sampling strategy was only partially achieved as five of the 11 participants were from a single university, which resulted in a heavier representation of experiences from one institution. The researchers sought to be attentive to this situation during analysis to avoid experiences from one institution overshadowing other institutional contexts. One of the challenges to recruitment for this study was that graduated occupational therapists often did not reply to alumni or alma mater generic emails. A possible solution to this situation in future studies of this type would be to attempt to recruit participants directly through associations or colleges of OT professionals.

Conclusion

This study aimed to address gaps in the literature for OT students who participated in IFW in low- to middle-income countries. Participant experiences were captured in four main themes of living in a new culture context, learning about different approaches and contexts of OT practice, supports and resources for carrying out IFW, and perceptions of how IFW affects students, clients, institutions, and host communities. The findings suggest that IFW can lead to increased awareness of cultural perspectives on health, illness, disability, and wellbeing. Some students who participate in IFW also associate their IFW experience with the development of improved clinical reasoning skills.

Important considerations in planning, organizing, and implementing IFW include pre-departure preparation, funding, choice of collaborative learning service models, realistic project objectives, commitment by the host institution, and flexibility amongst stakeholders. The findings reported in this article are broadly consistent with findings in the literature for both OT and other professional groups, such as nursing and physical therapy, and also highlight some distinctive facets of the experience of IFW for Canadian OT students (Taylor, 1995; Barker, Kinsella, & Bossers, 2010; Petrosoniak 2010; Crawford et al., 2010, Drynan, 2013). The results of this study can help inform universities as they plan components of pre-IFW preparation and ensure that funding and site selection are addressed with adequate resources for a successful learning experience. Participants in this study also expressed that IFW should be associated with sustainable projects that could benefit localities. Collaborative partnerships between sending and host institutions represent an important opportunity to facilitate knowledge exchange and sustainable contributions, thus enhancing international fieldwork education. Opportunities for future research include better understanding the needs and expectations of these key partners.

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Asylum Seekers' Human Rights in Australian Immigration Detention Centers:

What Role for Mental Health Practitioners?

Noémie Knebelmann I
McGill University, Montreal, Canada.

Abstract

This paper aims to identify the ethical dilemma faced by mental health practitioners in dealing with the way asylum seekers are treated in Australian detention centers. Drawing on recent research exploring the impacts of post-migration stressors on asylum seekers' physical and mental state and on the contentious living conditions in Australian detention centers, this paper puts forth the deleterious effects of Australia's immigration detention policies on the mental health of detainees. Furthermore, the role to be played by mental health practitioners in the defense of asylum seekers' rights in Australia must be questioned. The choice of working within an inhumane system or of denouncing it from the outside represents a dilemma that has no definitive answer, but that deserves to be discussed.

Pre-migration trauma suffered by forcibly displaced people (such as physical and/or sexual assaults, destruction of one's home, disappearance or death of loved ones, witnessing war and violence, etc.) greatly impacts their mental health, leading to extremely high rates of depression, post-traumatic stress disorder (PTSD), anxiety, self-harm, and suicidal ideations, among other psychiatric disorders (Silove et al. 1999; Steel et al. 2002; Mares et al. 2002). Yet, an increasing amount of literature now points to the major role of post-migration stressors in the emergence and perpetuation of trauma-related mental instability in these populations. Such stressors include the precarious situations of asylum seekers in host countries, the long and stressful refugee determination process, feelings of isolation and rejection stemming from the resettlement to a new country, among others. (Miller & Rasmussen 2009, Silove & Ekblad 2002, and others). In most cases, it has been shown that time is key to the healing of these ills. Indeed, a significant reduction in the prevalence and severity of refugees' mental health problems seems to occur over the course of resettlement (Murray et al. 2008). Still, this reduction is not guaranteed and there are great variations in the timing of the symptoms, with some depressive symptoms lasting, or even increasing, until up to 12 years after resettlement in some cases (Tran et al. 2007). Post-displacement conditions are thus of crucial importance when considering the physical and mental wellbeing of forcibly displaced migrants. Focusing on the mental health impact of post-migration detention on asylum seekers in Australia's contentious immigration detention facilities, this paper will investigate the role of psychiatrists and other mental health practitioners in the defense of detained asylum seekers' human rights. After addressing the controversies surrounding the issue of mental status assessment in displaced populations, the paper will present and critique Australia's immigration detention policy and the available evidence we have for its deleterious impact on the mental health of detainees. It will then explore the ethical dilemma faced by mental health practitioners in dealing with this situation and argue for the engagement of these specialists in human rights violation debates according to the tools at their disposal.

Both before and after forced migration, a key element to the validity and relevance of studies done on the psychological status of displaced persons is the assessment method. Indeed, there has been much controversy in recent years about the adaptation of current Western methods of mental status assessment for application in culturally and linguistically diverse communities. Individuals from these communities might have lived through traumatic events with which Western mental health practitioners may not be familiar. Many scholars have considered this 'cultural gap' a significant obstacle to the legitimacy of traditional Western mental health evaluation of displaced people (Hollifield et al. 2002). The debates surrounding psychiatric assessment have led to the development of several measures adapted to a variety of cultural and linguistic backgrounds and to various trauma experiences. Some of the ones that have been validated for refugee populations include the Allodi Trauma Scale, the Semi-structured Interview for Survivors of Torture, and the Harvard Trauma Questionnaire for assessing PTSD with torture survivors (Murray 2008). These frameworks have yielded what many consider satisfying results and are frequently used and accepted in academia, although some skepticism still remains (Hollifield et al. 2002).

Before looking into the mental health of detained asylum seekers in Australia, it is important to understand the factors that influence their mental status, such as the Australian immigration detention framework.

In Australia, detention facilities were established in 1989, mainly in response to the increasing number of asylum seekers arriving by boat from Cambodia. In 1992, the government passed the contentious policy of mandatory detention of all persons arriving on their territory without proper authorization or of those who over-stayed their visa validity period. Since 1994, the 273-day time limit of the detentions was removed, resulting in potential indefinite detention of asylum seekers (Silove et al. 2007). The Australian government affirms that the detention policy is key to state security. Yet, 90 percent of detained asylum seekers obtain Convention refugee status once their claim is processed, which leads the public to question the legitimacy of allegedly protecting the state to the detriment, as we will see, of the physical and mental state of vulnerable and innocent individuals.

The Australian detention facilities were modeled on correctional institutions in their architecture and way of functioning. Despite the recent ban, numbers instead of names are still widely used in many facilities; detainees are subjected to daily musters and are susceptible to placement in isolation units. The facilities are often overcrowded and there have been numerous allegations of mistreatment and of transfers to prisons. In addition to hunger strikes, riots, and other forms of protests, detainees are frequently exposed to violence such as acts of self-mutilation and suicide attempts (Silove et al. 2007, Steel et al. 2001). Some facilities were built in remote, isolated areas of the country with a harsher climate, leading to geographical, social and cultural disorientation of the detainees as well as to a strong feeling of exclusion and vulnerability; most of them are far away from refugee services or any kind of compatriot community (Silove et al. 2007). Neither the Australian Migration Act of 1958 nor any other binding legal document obliges the government or the immigration officers to provide the detained unlawful non-citizens with visa documents, legal advice, or any kind of information about refugee status. This leaves many asylum claimants unaware of their rights and vulnerable to deportation before their refugee claim has been heard (Schloenhardt 2002). However, the Australian government continues to support its claim of the administrative rather than punitive nature of detention (Newman et al. 2008).

There have been some changes in the immigration detention policy over the last decade, including these seven points discussed in a speech given by Senator Chris Evans at the Australian National University in 2008:

1. Mandatory detention is an essential component of strong border control.

2. To support the integrity of Australia's immigration program, three groups will be subject to mandatory detention:
 a. all unauthorised arrivals, for management of health, identity, and security risks to the community
 b. unlawful non-citizens who present unacceptable risks to the community
 c. unlawful non-citizens who have repeatedly refused to comply with their visa conditions.

3. Children, including juvenile foreign fishers and, where possible, their families, will not be detained in an immigration detention centre (IDC).

4. Detention that is indefinite or otherwise arbitrary is not acceptable and the length and conditions of detention, including the appropriateness of both the accommodation and the services provided, will be subject to regular review.

5. Detention in immigration detention centres is only to be used as a last resort and for the shortest practicable time.

6. People in detention will be treated fairly and reasonably within the law.

7. Conditions of detention will ensure the inherent dignity of the human person.
(Murray et al. 2008)

Still, despite these announcements, Australia's detention conditions remain questionable, and the policy still ignites controversies within the international community. Indeed, by signing the UNHCR Refugee Convention in 1951, Australia is under the obligation to assess refugee claims, which the detention policy, that has affected more than 20,000 individuals since its implementation in 1992, strongly impedes (Newman et al. 2013). Despite strong public outcry and numerous callouts from the United Nations Human Rights Committee affirming that Australia's detention policy is contrary to international law (for example in 1997, 2002, 2003, 2006, Newman et al. 2008), the High Court of Australia maintained, in 2004, that the Migration Act allowed for these detentions, and that they did not violate the Australian Constitution (Newman et al. 2008). The facilities thus continue to be used as a deterrent tool for asylum seekers, which appears to be plainly unlawful and shockingly neglectful of human rights.

The detention policy not only infringes upon the freedom of innocent detainees but also crudely ignores their human right to health, especially mental health. Indeed, the alarming environments of the centers have further raised concern over mental conditions of asylum seekers who, after traumatic experiences and forced departure from their homeland, are welcomed by this hostile environment. Although previous works had raised the issue of the psychological consequences of *detention, including Commissions of Inquiry initiated by Australian authorities (Silove et al. 2007), systematic scientific research on detainees' mental health in Australia started in 2004 with the publication of Steel and colleagues' study measuring the psychiatric status of 14 adults and 20 children detained for more than two years (Steel, Momartin et al. 2004). There is now flourishing evidence of the deleterious effects of detention gathered by studies using culturally sensitive assessment methods and usually carried out by investigators highly experienced in working with asylum seekers, and by asylum seekers themselves (HREOC 2004, Newman et al. 2008, Silove et al. 2007 and others). Such a study was conducted by an Iraqi medical practitioner seeking asylum in Australia and by a visiting psychologist in 2011 (Sultan & O'Sullivan, 2011). All results converge to ascertain that detention "is a negative socialization experience" that "exacerbate[s] the impacts of other traumas" (Murray et al. 2008). Chiefly, the studies reveal the dramatic effects of detention on children and consequences of long-term detention on most individuals (Murray et al. 2008, Newman et al. 2008, and others).*

Depression and anxiety were widespread in the asylum seeker populations studied, as well as self-harm, suicidal behaviour, and PTSD. Dudley (2003) estimates male rates of suicidal behaviour among detainees to be more than 40 times that of the national population, and 1.8 times higher than that of male prisoners (Murray et al. 2008). Child development was shown to be critically impaired due to many factors including few opportunities for cognitive development, dismantled family rituals, frequent exposure to violence, hostile and deprived physical environment, and strict security measures (HREOC 2004, Silove et al. 2007, Steel et al. 2004). Furthermore, detention directly impacted asylum seekers' sense of identity, safety, and self-worth (Newman et al. 2008).These findings raise some serious questions about the right of any government to be responsible for the brutal destruction of innocent individuals' most personal and essential values: what are they to do to once their life has lost any kind of meaning? Even after being released from the detention facilities for several years, many refugees suffered from persisting mental distress, especially among those held for more than 6 months (Steel et al., 2006). The long-lasting psychological and psychiatric scars created by the detention experience have significant impacts on the individual as well as on the societal level —given that most detainees are subsequently accepted into the Australian community (Newman et al. 2008).

In this context arises the issue of the lack of any kind of appropriate mental health care in the detention centers. Given Australia's responsibility in the creation or at least exacerbation of the detainees' mental conditions, is it not also its responsibility to heal these individuals? Yet, mental health specialists have repeatedly stated the impossibility for them to adequately alleviate the detainees' suffering within the detention setting, given that one of the major reasons for persistence of emotional problems was precisely the conditions in these prison-like centres, which maximize fear and exacerbate anxiety (HREOC, 2004). While many psychiatric reports and experts have advocated for better access to mental health care for the detainees, they have little control over the conditions of detention, the length of stay, and the lack of status resolution of the individuals. As stated by a senior child psychiatrist: “It is hard to conceive of an environment more potentially toxic to child development” (HREOC 2004). Hence, specialists feel disempowered in light of their inability to assist their patients and frustrated in face of this situation in which they appear to be containing mental illness rather than actually treating it (Newman et al. 2008).

It is interesting here to contrast this situation with the widespread scepticism about the capacity of Western mental health experts to effectively treat refugees and asylum seekers. In addition to the contentious assessment of mental illnesses in refugee populations, Western psychiatric philosophy is also criticized for its lack of cultural sensitivity in its interventions in these populations. I would like to stress the potentially detrimental effects of embracing this standpoint too strongly. In an article exploring the ways in which Western mental health workers are limited in their ability to understand the psychological needs of disaster-affected communities, the authors conclude that:

“One of the greatest errors is to over-rate the ability of outside helpers to understand and shape the recovery process and to under-rate the capacity of affected communities to draw on their own resources to guide and ideally lead these activities.”

(Silove et al. 2005; p.123)

Although this is greatly supported by evidence pointing to the slippery slope of imposing Western psychological theories to culturally diverse populations, how should this quote be interpreted in our case? I fully agree that this issue should be comprehensively investigated and that Western approaches should thoroughly acknowledge their limited understanding of these individuals and reflect it in their scope of action. Yet, the risk of taking such conclusions too literally can have major impacts. In fact, what kind of “recovery process” can be discussed? The recovery of trauma in incarceration-like facilities? Recognizing our limitations should not prevent us from recognizing our potential to help and our right and obligation to condemned human rights abuse, wherever they might appear.

This leads us to consider the role of mental health professionals witnessing human rights violations, and the ethical dilemma they are faced with. Should the Australian mental health experts work “for a damaging system” (Newman et al. 2008), adapt their therapies to the abusive detention system, while trying to overcome its deleterious effects? Or should they reject it fully and try to ‘oppose it from without’, by providing evidence of its harmful impact and trying to shame the government into changing policy? The outcome seems potentially harmful in both cases.

The role of medical professionals in the political arena might not seem obvious. It is commonly believed that health practitioners’ ‘mandate’ is to act for the wellbeing of their patients. However, this can be approached in various ways. They can be seen as neutral entities that are to observe their duty regardless of the characteristics of their patient or work setting. However, this view is at risk of reducing health professionals to puppet-like non-agents that simply heal those who come to them without reflecting on the morality of their work. This representation can be brought back to the debate about agency under the pressure of authority, such as the role and responsibilities of physicians under the Nazi regime. Another way to think about the role of health professionals is one in which they are to strive for an enhanced health status of their community and of human beings as a whole while balancing personal moral values that cannot be ignored in the professional sphere. This can include taking a stance against conditions, policies, or actions that significantly affect the health of a particular individual or group, as well as closely scrutinizing government decisions concerning vulnerable groups, investigating on and providing evidence for the harm done to some individuals, as well as openly advocating for a particular cause. This form of engagement (political or not) is not new and has been successfully used many times to denounce harmful situations that had not been properly addressed. A recent example of political engagement of health practitioners is the assembly of health care workers across Canada to create the "Canadian Doctors for Refugee Care" group in order to oppose the government's decision in 2012 to significantly cut the Interim Federal Health program, the refugees' health insurance in the country. In our case, the Australian mental health practitioners are faced with issues that are quite similar to the Canadian doctors, and the ultimate question thus arises: How should they react to the human rights violations they are witnessing in the detention centers? Should they take a political stance? Should they unite to oppose the government like the Canadians have done?

In fact, undertaking studies to prove an obvious point about the harmful impact of detention on mental health is already a step taken against the government's policy, since these studies seem to show quite explicitly the wrong-doings of the Australian authorities. Indeed, Newman et al. (2013) emphasize the fact that these kinds of studies are never 'value-free'; they are accompanied by a moral imperative to denounce human rights violations and abuses of vulnerable groups, and these underlying values represent a major goal of these studies. This engagement of one's moral values in the professional sphere has in fact proven fruitful, considering the changes in Australian policy such as in 2008, which were argued to be greatly influenced by the findings of such studies and the general public discontent they provoked. For Silove et al. (2007), "it seems evident that the deleterious mental health impact of detention was pivotal in public discourse." Indeed, the Australian Government now recognizes the mental deterioration of vulnerable people induced by long-lasting detention and has established the Detention Expert Health Advisory Group, which includes mental health professionals, in 2006. Hence, demonstrating what one might consider obvious can sometimes be considerably valuable in unveiling human rights violations or convincing unwilling actors of the ugly truth. The efforts of such mental health experts in undertaking engaged research against inhumane treatments, overcoming obstacles such as the need to bypass the Immigration Department for ethics approvals, and facing accusations from the Department of the falsehood of their results and the biased nature of their study due to their advocacy standpoint are thus particularly admirable (all of which occurred for Steel and Silove's study in 2004).

However, although the influence of this engagement has made its proofs in the political sphere, mandatory detention remains a pillar of Australian immigration policy, and the battle is not over. The rejection of this harmful practice by many mental health professionals and the strength of their ethical standpoint should be supported and admired. Yet, coming back to the dilemma of choosing between working within the system versus combatting it from the outside, there should be concerns about the slow speed of policy changes and the consequences on the asylum seekers currently detained. Indeed, if all mental health workers stopped cooperating with the Immigration Department and providing the limited care they could provide, how much would the detainees' psychiatric state further deteriorate? Admittedly, there has been very little evidence of the impact of such mental health interventions in detention centers (Murray 2008), and as we have seen, the experts themselves are quite pessimistic about their ability to relieve symptoms in this setting. Yet, if all efforts are halted, no data will be needed, for there will definitely be no health improvement. Therefore, although there seems to be no ultimately right answer to this complex ethical dilemma, the importance of trying to integrate the system to assist the people in need as rapidly as possible should not be overlooked, ideally while openly condemning the status quo.

In conclusion, despite the controversies surrounding the adaptability of Western mental health philosophy to a forced-displacement context, it has repeatedly been proven that the detention conditions in Australia produce deep and long-lasting psychiatric scars that add on to the pre-existing trauma of forced migrants, especially children. Although framed here through the lens of psychiatric distress, the combat against prolonged and arbitrary detention is fundamentally grounded in a human rights discourse. Indeed, using the mental harm induced by mandatory detention as a potent lever to provoke change in Australian policy brings to the forefront the role of health professionals in the human rights violation debate. They are faced with a complex ethical dilemma concerning the professional choice of either working within an inhumane system, or denouncing it from the outside. This paper clearly highlights the need for mental health specialists to proactively combat this harmful framework by using not only their tools, which can include their expertise, their ability to professionally interact with the distressed in order to reduce their suffering, and their capacity to undertake engaged research independently from the government, but also their agency as health professionals but also as human beings, and their rights and obligations regarding human rights abuses. Mental health professionals in Australia and around the world, as well as every individual in their own domain, should be urged to take advantage of the means they possess and of their rights and their agency as human beings in order to condemn the wrongdoings and abuses of any individual or group, even when this group is one's own government.

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Examining Barriers to Maternal Health Care in Kenya Using the Three-Delay Framework

Stuart Davidson I
McMaster University, Hamilton, Canada

Abstract

Objective: This paper examines the impact of multiple perceived and actual barriers on the demand and utilization of preventive and emergency maternal health care in Kenya. Results were used to formulate comprehensive health policy suggestions for future improvements in maternal health outcomes in Kenya.

Method: Gabrysch & Campbell's (2009) adapted version of Thaddeus & Maine's (1994) "three-delay" framework was used to analyze the impact of four barriers-to-care on women's decision to seek preventive or emergency maternal care in Kenya. These barriers include: (1) physical accessibility, (2) economic accessibility, (3) the perceived benefits and quality of care, and (4) sociocultural obstacles. Each barrier may delay care-seeking outcomes in three phases: delay in considering to seek care (Phase I), delay in identifying and reaching health facility (Phase II), and delay in receiving adequate and appropriate emergency obstetric care (Phase III).

Results: While each barrier individually contributes to delays in care-seeking outcomes, they also interact synergistically within their contextual environments. Due to Kenya's constrained and debilitated health care system, quality of care represents a notable barrier for improving care-seeking outcomes.

Conclusions: Improvements in the demand and utilization of maternal health care in Kenya requires the government to consider new legislative policies to strengthen its health care system, improve quality of care, and ensure the equal distribution of financial and human resources among the counties. Furthermore, it is critical that new maternal health interventions are developed upon a participatory community-based approach, involving a close partnership with community leaders and local government ministries.

As Canada continues to demonstrate its commitment to improving global maternal, newborn, and child health (MNCH) – most recently, by pledging an additional $3.5 billion over the next five years (2015-2020) to scale-up global initiatives (Government of Canada, 2014) – it is time for researchers and project developers to closely re-examine factors that impact MNCH outcomes. This article examines maternal mortality and morbidity in Kenya using Gabrysch & Campbell's (2009) adapted version of Thaddeus & Maine's (1994) "three-delay" framework (see Figure 2). This framework expands on behavioural models of health care demand and utilization – examining both perceived and actual barriers to both – and their impact on a woman's decision to seek preventive or emergency maternal care. While the contextual elements of each barrier discussed in this article are specific to Kenya, the lessons learned from their examination can be applied worldwide.

Global Maternal Health

Articles pertaining to global maternal health often greet their readers with three facts: (1) worldwide, nearly a thousand young healthy women die each day due to complications of pregnancy or childbirth (UNICEF, 2014); (2) it is estimated that nearly 90 percent of these deaths could have been avoided had the women received competent professional medical care (WHO, 1986); and (3) in 2013, there were approximately 289,000 maternal deaths worldwide, with a maternal mortality ratio (MMR) of 210 maternal deaths per 100,000 live births (UNICEF, 2014). These facts are a disheartening reminder of the tremendous loss of life and of the enormity of challenges that lay ahead; in some developing countries, lack of equipment, training, and information systems required to accurately identify and register maternal mortality may indicate that these numbers are a gross under-estimation of the true number of maternal deaths worldwide (UNICEF, 2014).

Despite the significant gains in maternal health currently being made in Nepal, Cambodia, Rwanda, and Laos, there continue to be major global disparities between regions and income groups (Hussein, Blanc, Donnay, McCaw-Binns, & Webber, 2012; UNICEF, 2014). This disparity is most clearly demonstrated by current estimates that approximately 98 percent of global maternal deaths occur among the poorest and most vulnerable groups in developing countries (Hussein et al., 2012; UNICEF, 2014). Women in developing countries are 23 times more likely to die because of pregnancy or childbirth related complications than women in developed regions of the world (See Figure 1) (UNICEF, 2014). The sub-Saharan region alone accounts for 62 percent (179,000) of global maternal deaths, and has the highest regional maternal mortality ratio (MMR), with approximately 510 maternal deaths per 100,000 live births. In short, maternal mortality continues to be disproportionately higher in developing regions of the world and its burden is borne almost exclusively by the poor.

Maternal Health in Kenya

While many regions of the world have made significant progress in reducing maternal mortality since 1990, sub-Saharan Africa has had minimal success in doing so. In 2013, the MMR in Kenya remained unchanged at 488 deaths per 100,000 live births. With 6,300 maternal deaths, Kenya suffered the eighth highest burden of maternal death worldwide (UNICEF, 2014). Kenya's failure to reduce its MMR is likely related to the decline in the number of deliveries attended by skilled healthcare professionals, such as trained physicians, nurses, or midwives, which fell from 50 percent in 1989 to 42 percent in 2003 (CBS, MOH, ORC Macro, & ORC Macro, 2004). Interestingly, despite approximately 92 percent of women having at least one antenatal appointment in Kenya, suggesting the reasonable availability of maternal health care, the skilled birth attendance rate remains relatively low (KNBS & ICF Macro, 2010). These discouraging findings support a body of literature, which suggests an increase in the supply and availability of maternal health care does not necessarily result in increased access to, or use of, maternal health care services (Kerber, De Graft-Johnson, Bhutta, Okong, Starrs, & Lawn, 2007; Kitui, Lewis & Davey, 2013; PMNCH, 2006).

International Response to Maternal Health

To prevent maternal mortality and morbidity, risk factors signalling life-threatening complications, such as haemorrhage, pre-eclampsia and eclampsia, puerperal sepsis, and obstructed labour must be identified early and managed effectively (Adegoke & Van Den Broek, 2009; Ashford, 2002). The "Skilled Birth Attendance Strategy" is recognized by the WHO as the most effective intervention for reducing maternal mortality and morbidity; this two-part strategy focuses on strengthening health care systems by facilitating access to both skilled health care professionals and maternal health care facilities (Adegoke & Van Den Broek, 2009; WHO, 1999). Adequate maternal health care requires both access to skilled health care professionals, such as doctors, nurses, or midwives, as well as necessary maternal health services, such as antenatal care, postnatal care, emergency obstetric care, safe abortion, and skilled birth assistance (Adegoke & Van Den Broek, 2009; Bhutta et al., 2010).

While the scope of this paper is primarily concerned with barriers preventing pregnant women from accessing maternal health care services, the importance of family planning initiatives should not be understated. Family planning strategies, such as contraception, elective abortion, and assisted reproductive technology, protect against maternal mortality and morbidity both directly, by avoiding unwanted pregnancy and unsafe abortion, and indirectly, by promoting the empowerment of women and the reduction of poverty and malnutrition (Cleland et al., 2006). While national family planning programs in countries throughout Asia and Latin America have had success in reducing fertility rates, many countries in sub-Saharan Africa, including Kenya, still experience high unmet need for family planning and high fertility rates (Cleland et al., 2006; KNBS & ICF Macro, 2010). National survey reports reveal that only 46 percent of women in Kenya use contraceptives and that approximately 43 percent of pregnancies were unplanned (KNBS & ICF Macro, 2010). These findings indicate the necessity of implementing family planning strategies within maternal health initiatives in Kenya, as well as the importance of utilizing a multifaceted approach.

Availability (Supply) and Accessibility

While implementing safe clinical obstetric interventions remains the primary focus of nearly all maternal health programs, expanding maternal health coverage requires more than an increase in the supply of services (Hussein et al., 2012; PMNCH, 2006). An increase in the supply of health facilities does not always result in greater accessibility, and despite the presence of facility-based services, utilization rates during delivery may remain low in many developing countries (Kerber et al., 2007; Kitui, Lewis & Davey, 2013; PMNCH, 2006). It is estimated that more than 50 percent of women in developing countries continue to deliver at home, only 41 percent of these deliveries attended by a traditional birth attendant, and clinical obstetric proficiency among these attendants varying widely (Montagu, Yamey, Visconti, Harding, & Yoong, 2011).

It goes without saying that all mothers desire a normal and safe pregnancy that results in the birth of a healthy child. However, for women living in developing countries, this is often not a matter of simple choice. A woman's decision to seek preventive maternal care and professional medical assistance during labour is not dependent upon any one factor exclusively, but is instead the result of a complex combination of potential barriers that form the context for her decision-making. (Bradley et al., 2012; Gabrysch & Campbell, 2009; Hussein et al., 2012; Kitui, Lewis & Davey, 2013; PMNCH, 2006; Thaddeus & Maine, 1994). These barriers are often unique to each community and form the context against which decisions are made; they may include physical barriers, financial barriers, sociocultural barriers; and the perceived quality of care. (Hussein et al., 2012; PMNCH, 2006). To successfully reduce global maternal mortality and morbidity, it is critical that interventions extend beyond medical obstetric care, and build upon an understanding of the local contextual barriers that influence access to, and demand for, maternal health care (Hussein et al., 2012).

Barriers to Essential Maternal Health Care Services in Kenya: The "Three-Delay" Framework

This paper examines maternal mortality and morbidity in Kenya using Gabrysch & Campbell's (2009) adapted version of Thaddeus & Maine's (1994) "three-delay" framework (see Figure 2). This framework expands on behavioural models of health care demand and utilization and examines the impact of four barriers-to-care on a woman's decision to seek preventive or emergency maternal care. These perceived or actual barriers include: (1) physical accessibility, (2) economic accessibility, (3) the perceived benefits and quality of care, and (4) sociocultural obstacles. Each barrier may delay care-seeking outcomes in three phases: delay in considering to seek care (Phase I), delay in identifying and reaching health facility (Phase II), and delay in receiving adequate and appropriate emergency obstetric care (Phase III).

For example, a woman's perception of the financial accessibility of antenatal care, or of a facility-based delivery, may prevent her from considering either of these options (Phase I). If she does decide to take advantage of these health care options, her ability to pay for them may make doing so impossible, or at least significantly more difficult (Phase II). Gabrysch & Campbell's (2009) adapted "three-delay" framework will be used to outline and examine potential barriers and the impact they have on care-seeking behaviours in the Kenyan context (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994).

Physical Accessibility

Physical accessibility, indicated by the distance separating a pregnant woman and the nearest maternal health facility, can create both a Phase I and Phase II delay in maternal health care seeking behaviours. While the perceived distance of a maternal health facility may prevent the consideration of facility-based care, the actual distance may prevent any possibility of reaching a maternal health facility should a complication arise (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994). Understandably, even if a woman intends to deliver in a maternal health care facility, she may abandon the idea of travelling extended distances during labour, especially at the thought of enduring a ride through rough terrain, or worse, a journey on foot. Attempts to travel extended distances are often unsuccessful, and in the event of complications, the mother often dies en route. The difficulties posed by this barrier are often exacerbated when women live in rural regions of developing countries with poor roads and limited options for transportation and communication (Gabrysch & Campbell, 2009; Mrisho et al., 2007; Thaddeus & Maine, 1994). Nearly 76 percent of Kenya's population lives in rural communities, where the above conditions are fulfilled. Distance and transportation therefore would appear to represent significant barriers to accessing maternal health care (Population Reference Bureau, 2013).

This observation is, at first, supported by reports that show that distance or lack of transportation, are the most commonly cited reasons that women in Kenya give for choosing not to deliver at a professional health care facility (Kitui, Lewis & Davey, 2013). However, while distance and transportation may be perceived as the most important barrier to maternal health care, nearly 90 percent of mothers in Kenya live less than 5km from a health care facility staffed by at least one skilled health care professional and, as previously discussed, more than 90 percent attend at least one antenatal appointment (KNBS & ICF Macro, 2010; Kitui, Lewis & Davey, 2013). Moreover, after controlling for other variables, statistical measurements indicate no significant correlation between the distance and the location of delivery (Kitui, Lewis & Davey, 2013). It therefore seems that distance and lack of transportation cannot alone explain the existence of Phase I and Phase II delays.

These findings suggest that the importance of distance and transportation may be due to a complex interaction with other barriers, such as financial cost, perceived or actual quality of care, and severity of labour, delivery, or complications (Gabrysch & Campbell, 2009; Mrisho et al., 2007; Thaddeus & Maine, 1994). For example, women may be more likely to abandon the thought of travelling extended distances if a medical facility is thought to provide low quality care. Alternatively, women may choose to travel further to more desired health facilities if the quality of care is perceived to be superior (Anson, 2004; Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994). The undesirable thought of enduring an extended journey to a health care facility, augmented by the financial cost of locating and hiring transportation, may deter women from seeking professional medical assistance (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994).

Economic Accessibility

The use of maternal health services throughout pregnancy and delivery can often incur considerable financial costs, including direct transportation costs, medication and supply costs, and fees for health care personnel and facilities (Filippi et al., 2006; Gabrysch & Campbell, 2009; Storeng et al., 2008; Thaddeus & Maine, 1994). Despite being encouraged to plan for deliveries, the unpredictability of delivery outcomes and costs often function as a disincentive for women to save for emergency care (Parkhurst & Rahman, 2007; Storeng et al., 2008). Women in Tanzania report that the fear of potential costs alone deterred them from seeking maternal health care (Kowalewski, Mujinja & Jahn, 2002). As a result, households with limited budgets may be unwilling, unprepared, or incapable of shouldering the expense of professional maternal health care services (Parkhurst & Rahman, 2007; Storeng et al., 2008). These findings suggest that financial accessibility acts as both a Phase I and Phase II barrier, inhibiting the initial decision to seek maternal health care, as well as the actual ability to receive emergency obstetric care should complications arise (Gabrysch & Campbell, 2009; Kitui, Lewis & Davey, 2013; Kowalewski, Mujinja & Jahn, 2002; Mrisho et al., 2007; Thaddeus & Maine, 1994).

The fact that many individuals and families cannot afford essential health care services, and the relationship of this fact to poor health outcomes, has forced health care financing onto the global health agenda. As a result, many developing countries, including Kenya, are now considering various health financing reforms, which modify how public funds are collected, pooled and managed, and spent. National health systems continue to work toward universal coverage by implementing policies that promote equitable access to key health care services for all people at an affordable cost (Chuma & Okungu, 2011; McIntyre, 2007).

In response to an economic downturn in 1989, and after more than 25 years of fully publicly funded health care, Kenya reintroduced health care user fees, including fees for medications, injections, and laboratory services (Chuma & Okungu, 2011). These reforms prompted a surge in the private health care sector, which currently operates nearly 50 percent of health care services in Kenya (Chuma & Okungu, 2011; MoMS, 2008). By 2004, worsening poverty and poor utilization rates led to the introduction of the "10/20" policy. Under the new policy, instead of user fees, individuals would pay a single registration fee of KSH 10 for services at health dispensaries (public outpatient health facilities providing health services for simple ailments) and KSH 20 for services at health centres (public out/inpatient health facilities providing preventative and comprehensive primary care services). Furthermore, children under the age of five and those with special conditions, such as patients with malaria and tuberculosis were completely exempt from all health service fees (Chuma & Okungu, 2011; CREHS, 2009; Muga, Kizito, Mbayah, & Gakuruh, 2005). Due to budgetary constraints, adherence to the "10/20" policy has been extremely low, and many health facilities continue to charge user fees under the direction of district level managers and health committees (Chuma & Okungu, 2011; CREHS, 2009).

The impact of financial accessibility on the use of health care services in Kenya is magnified by the country's exceedingly low rate of insurance coverage. Women from wealthier households or those with health insurance coverage are significantly more likely to seek professional maternal care (Kitui, Lewis & Davey, 2013). Unfortunately, in 2011, Kenya's health insurance coverage remained at only 7% (Joint Learning Network, 2014), restricted to mainly urban (Jacobs, Ir, Bigdeli, Annear & Van Damme, 2012; MoMS & MoPHS, 2009), and wealthy populations (MoMS & MoPHS, 2009). The National Hospital Insurance Fund (NHIF) is Kenya's state health insurance corporation, and primary provider of health insurance in the country. While membership to the NHIF is currently mandatory for workers in the public and private formal sector in Kenya (Chuma & Okungu, 2011), the formal sector only represents 11 percent of the Kenyan workforce; the majority of workers are located in the irregular, untaxed, and self-employed informal sector (Government of Kenya, 2012). They are therefore not required to purchase an insurance plan. Voluntary NHIF membership is currently available for all Kenyan residents at a minimum rate of KSH 160 per month (Chuma & Okungu, 2011), however, enrolment remains low due to lack of knowledge about the program, its registration process, and the types of medical services covered (Mathauer, Schmidt & Wenyaa, 2008).

As a result, Kenyans continue to endure either significant user fees from the public health sector or high costs from the private sector, both leading to exorbitant annual household health care costs. In 2006, household out-of-pocket payments, including all direct and in-kind payments for health care services, pharmaceuticals, and therapeutic appliances, accounted for approximately 29 percent of total health expenditure in Kenya (Government of Kenya & Health Systems 2020 Project, 2009). These out-of-pocket payments for health care services accounted for nearly 10 percent of Kenya's average annual household budget, and were of course a much larger proportion of the budgets of poorer households. Approximately 45.9 percent of the total population in Kenya already lives below the national poverty line (World Bank, 2014). And as a result of these expenditures, many more Kenyan households are forced into acute poverty each year (Chuma & Maina, 2012),

On June 1, 2013, Kenyan President Uhuru Kenyatta attempted to address this issue by announcing that all maternal health care fees in public health facilities were to be abolished immediately. Under the new policy, the Kenyan government will reimburse all public and maternal health care facilities, including those operated by faith-based or non-governmental organizations, for each delivery they conduct (Health Policy Project, 2014; Richard et al., 2013). The free maternal health policy is still in its pilot phase, limiting benefits to specific regions of Kenya and parts of Nairobi. Furthermore, it is heavily dependent on donor funding, making sustainability difficult to ensure. Despite these potential limitations, it is still early to formulate an accurate evaluation of the implementation and effectiveness of this policy (Richard et al., 2013). While free maternal health care may be a step in the right direction, Kenya's public health sector remains significantly underfunded and understaffed (KNCHR, 2013), which has resulted in overcrowded health facilities, poor service quality, and reports of women still preferring to deliver at home with friends and family or with a traditional birth attendant (Gathigah, 2013).

Interestingly, while a review of the evidence suggest that financial cost greatly influences the women's decisions to seek maternal care during pregnancy and delivery, and their ability to do so, (Gabrysch & Campbell, 2009; Kitui, Lewis & Davey, 2013; Kowalewski, Mujinja & Jahn, 2002; Thaddeus & Maine, 1994), only 7 percent of the poorest women in sub-Saharan Africa reported cost as a deciding factor (Montagu et al., 2011). While it is possible that women in sub-Saharan Africa underestimate the influence of financial cost on the decision to seek maternal health care, it is more likely that like distance, financial cost is part of a complex combination of various barriers such as quality of care, and other sociocultural factors, that together impede women's ability to access maternal services.

Quality of Care

Limited financial and human resources in many developing countries have resulted in health care systems with disastrously poor quality of care (Bhutta et al., 2010; UNICEF, 2014). Most developing countries spend less than 15 percent of their national budget on health, while international assistance for maternal, newborn, and child health accounts for only 31 percent of total funding. As a result, quality of care continues to fall, while out-of-pocket expenditures soar (Bhutta et al., 2010). Only 10 percent of developing countries sustain a minimum of 23 physicians, nurses, and midwives per 10,000 people – a number identified by the WHO as the minimum number of health personnel required to safely and effectively deliver essential health services (Bhutta et al., 2010; UNICEF, 2014; WHO, 2014).

Along with acute shortages of health personnel, health care systems in developing countries often suffer from the unequal distribution of financial and human resources, shortages in medication, and poorly equipped health facilities. As a result, public health facilities may provide unacceptably low quality of care and may even be avoided by the public (Bhutta et al., 2010; Hussein et al., 2012; UNICEF, 2014). Many populations living in developing regions face not only the greatest burden of maternal deaths and disability but also limited access to essential maternal health care of acceptable quality (Bhutta et al., 2010; UNICEF, 2014).

A review of various national health surveys conducted in developing countries indicates that 68 percent of women who delivered outside a health facility reported that it was "not necessary" (Montagu et al., 2011). These findings suggest that quality of care not only influences the actual outcome of maternal care (Phase III), but also the perceived benefits and necessity and therefore demand (Phase I), of maternal care at professional health care facilities (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994). This perception is shaped by a complex combination of past individual or community experiences with pregnancy or health facilities, sociocultural attitudes towards health care facilities and personnel, and knowledge of health and maternal complications (Gabrysch & Campbell, 2009; Hussein et al., 2012; Koblinsky et al., 2006). For example, past experiences and rumours of poor treatment from health care personnel, limited availability of supplies or services, unhygienic facilities, and extended waiting times, may overcome any perceived benefits of maternal care, and significantly deter women from seeking care (Gabrysch & Campbell, 2009; Mrisho et al., 2007; Paxton, Bailey, Lobis, & Fry, 2006; Thaddeus & Maine, 1994).

Negative rumours, past experiences and perceptions of facility-based care may be caused by cultural conflicts between modern medical 'culture' and the local culture of women in the community. These conflicts may stem from lack of privacy, restrictions on the presence of family members, and the lack of compassionate treatment by health care personnel (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994). In many studies, women report rude, arrogant, disrespectful, and even neglectful behaviour at health care facilities (Gabrysch & Campbell, 2009; Kyomuhendo, 2003; Mrisho et al., 2007; Muckle, Sprague, & Fergus, 2013; Thaddeus & Maine, 1994). As a result, many women prefer the assistance of a traditional birth attendant or relative and would rather risk delivering at home (Gabrysch & Campbell, 2009; Kyomuhendo, 2003; Mrisho et al., 2007; Muckle, Sprague, & Fergus, 2013; Thaddeus & Maine, 1994).

The Government of Kenya spends only US$14 per capita on health care services annually (PMNCH, 2012), falling significantly short of the WHO's recommended US$44 per capita (WHO, 2012). Constrained by insufficient financial resources, and lacking support from legislation, management expertise, and efficient information and communication systems, the health care system in Kenya is plagued by numerous weaknesses. These weaknesses include an acute shortage of health care personnel and unequal distribution of financial and human resources among regions and various levels of facilities (PMNCH, 2012).

Health care personnel are the foundation of an efficient health system, however, each of Kenya's 47 counties have yet to reach the government's target of 36 physicians for every 100,000 people (International Budget Partnership, 2013). Universities and training facilities in Kenya produce less than half of the required health care workforce each year, and retention of staff, especially in rural regions, continues to be a serious concern (Chankova, Muchiri, & Kombe, 2009; USAID Kenya, 2013). High rates of attrition for doctors and registered nurses are commonly attributed to low pay or poor living and working conditions (Chankova, Muchiri, & Kombe, 2009).

Limited financial and human resources have placed significant strain on Kenya's health system and health care workers. In late 2013, health workers in Kenya went on strike in protest of the collapsing health care system, citing shortages of health care personnel, equipment, and necessary medications. The stressful impact of these working conditions were revealed to the Kenyan public when video footage surfaced online showing a woman delivering her child on the floor of a public hospital, while being slapped by attending nurses and told to walk to the appropriate ward (Dahir, 2014).

The importance of perceived quality of care as a variable in this analysis is further dependent on its interaction with other factors. As previously discussed, women may be unwilling to travel any distance from the comforts of home to a health care facility if they perceive little or no benefit and expect poor quality of care (Anson, 2004; Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994). The thought of having to incur significant costs and even debt for a delivery at a low quality health care facility with potentially abusive staff is unthinkable, and is likely to deter many women from even considering professional health services (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994).

Therefore, strengthening the health system and improving the quality of care in Kenya, and therefore increasing accessibility to it, is crucial for improving utilization rates and reducing maternal mortality and morbidity (Bhutta et al., 2010; Paxton et al., 2006). Members of the community must be confident that they will receive supportive and respectful care with all necessary equipment, health care professionals, and drugs available, at an affordable cost (Kitui, Lewis & Davey, 2013;Thaddeus & Maine, 1994).

Sociocultural Factors

Sociocultural factors, including ethnicity, religion, norms, values, and traditions, and their influence on personal and societal elements, such as wealth, education, and autonomy, act as powerful determinants of whether women choose to seek maternal health care during pregnancy or delivery. The depth and complexity of these factors and their influence on health care seeking behaviours are further intensified by their potential synergistic and/or independent impact. While these factors may encourage the use of health care facilities, they may also be factors contributing to increased risks of obstetric complication or targets for discrimination or exclusion. The interaction of these barriers, and their impact on all of the barriers previously discussed, produce highly complex Phase I and II delays (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994).

Socioeconomic standing, potentially associated with ethnicity and religion, has significant implications in determining levels of education and location of residence. High levels of education are consistently associated with increased rates of facility-based delivery (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994). This effect is most likely associated with the benefits of increased levels of education and literacy, such as increased knowledge and awareness of health information and services, socialization to medical 'culture,' access to financial resources, self-confidence, and better coping and negotiation skills. These benefits facilitate the development of autonomy for women, which translates to more decision-making power, personal empowerment and better ability to demand maternal health services (Gabrysch & Campbell, 2009; Hussein et al., 2012; Navaneetham & Dharmalingam, 2002).

The positive impact of wealth and education for maternal outcomes has been documented in Kenya, where wealthy and highly educated women living in urban regions are significantly more likely to seek skilled assistance during delivery (Kitui, Lewis & Davey, 2013; Ochako et al., 2011). Unfortunately, significant financial, educational, and opportunity-based inequalities exist within Kenya, specifically between Kenya's 42 tribal ethnic groups (World Bank, 2008). Historical accounts suggest that this variability may be related to historic ethnic inequalities in the distribution of financial resources from the government, which affect education, future opportunity, and wealth (Alwy & Schech, 2004). National health surveys in Kenya reveal significant variability between Kenya's tribal ethnic groups and the location of delivery; Luhya women were significant less likely to deliver in a health facility compared to their Kalenjin, Kikuyu, Meru, and Somali counterparts (Kitui, Lewis & Davey, 2013). These findings further suggest the presence of ethnic inequality in Kenya, as well as its influence on the barriers preventing access to maternal health care in Kenya.

Under-utilization and lack of demand for maternal health care may also be the result of a cultural conflict between medical 'culture' and the local cultures of a community. Common medical practices at health care facilities, such as use of the supine birthing position, medical treatment from young or male health care personnel, limited access to family members during delivery, and limited privacy, may result in a socially inappropriate and uncomfortable experience for the woman. These potential experiences, and even the idea of delivering a child in a health care facility, may challenge the norms, values, and beliefs of that are central to a community (Gabrysch & Campbell, 2009; Mrisho et al., 2007; Thaddeus & Maine, 1994).

Sociocultural factors relating to ethnicity and religion may more directly contribute to an increased risk of obstetric complications. For example, some traditional beliefs in East Africa suggest that obstructed labour is caused by infidelity, deterring women from seeking facility-based care, especially if obstructed labour complications arise (Gabrysch & Campbell, 2009; Mrisho et al., 2007; Thaddeus & Maine, 1994). This direct impact may also result from traditional practices, such as early marriage and pregnancy.

Despite national laws and various efforts from international health organizations, early female marriage continues to be practised in many developing countries, including Kenya. Girls as young as fifteen are wed in arranged marriages; early marriage is associated with early pregnancy, which can have significant negative health implications for both women and children (Jensen & Thornton, 2003; Lewis & De Bernis, 2006). Young pregnant women, because they have under-developed pelvic structures, are at significantly greater risk of suffering obstructed labour, obstetric fistula, or death. This is especially true of those women who are impoverished or malnourished. (Lewis & De Bernis, 2006).

Sociocultural factors also influence accessibility to maternal health by way of their impact on legislative policy. The Government of Kenya's restrictive abortion laws, coupled with its failure to address the causes of unwanted pregnancy, has resulted in a significant number of unsafe abortions. The restrictive laws fail to address demand and leave women with little choice but to risk their lives. As a result, more than 2,600 women die each year from unsafe abortions in Kenya, with more than 21,000 suffering related morbidity. The significant moral and value-based context of fertility, contraception and abortion, make these issues controversial and difficult to address, despite significant maternal mortality and morbidity (Center for Reproductive Rights, 2010).

The Way Forward

Effective resolution of Kenya's maternal mortality burden requires a comprehensive understanding of the contextual, geographic, economic, and sociocultural barriers, which are further augmented by the country's high fertility rate and an under-financed and debilitated health care system. Gabrysch & Campbell's (2009) adapted "three-delay" framework reveals the unique interaction of each barrier and both their perceived and actual impact maternal care-seeking behaviours, demand, and utilization (Hussein et al., 2012; PMNCH, 2012).

Findings indicate that strengthening the health care system and improving perceived and actual quality of care and benefits of seeking maternal health care is critical for scaling-up the rate of maternal health care service use in Kenya (Koblinsky et al., 2006; PMNCH, 2006). Reports of poor and insensitive treatment, negligence, and shortages of health care personnel threaten the reputation and perceived value of these services (Gabrysch & Campbell, 2009; Kyomuhendo, 2003; Mrisho et al., 2007; Muckle, Sprague, & Fergus, 2013; Thaddeus & Maine, 1994). The revitalization of Kenya's health care system requires not only an increase in funding but also a two-part strategy targeting improvements in health care personnel training and management, and health care system infrastructure and supply (Atherton, Mbekem, & Nyalusi, 1999).

Poor quality of care and acute shortages of health personnel should be addressed promptly by strategies for increasing health care personnel and management personnel training, deployment, and retention (Koblinsky et al., 2006). Unsurprisingly, health care personnel and management personnel are a critical determinant of the level of quality in health care facilities. Their performance is often an indicator of their competence, motivation, and available resources. Therefore, the education and training of health care personnel and management personnel must be a priority for health ministries in Kenya. It is essential that the learning needs and demands of health care personnel are first assessed, and that they are then provided through continued education. In-service training exercises, such as active learning opportunities and discussions, should be provided with continuous physician-learner interaction. To improve quality of care in public health facilities, training should be context-focused and target knowledge capacity and culturally adequate and acceptable care (Koblinsky et al., 2006). Furthermore, management personnel must be trained to maintain close relationships with health officials and community leaders based on enhanced communication, information, and referral systems. These practices promote the establishment of an inclusive and contextually-informed community-based health system, which better facilitates the mobilization of community members into health facilities (Bradley et al., 2012; Koblinsky et al., 2006; Lee et al., 2009; PMNCH, 2006).

Limited and unequal distribution of human resources has had a devastating impact on the quality and accessibility of maternal care in Kenya. While deliveries conducted by an obstetrician may be ideal, Kenyan health officials must consider alternative options for training skilled birth attendants. Multipurpose community health workers can be trained in assistant midwifery in six months to conduct home deliveries; midwives and assistant midwives may also join together with obstetricians and registered nurses to establish community birthing centres. Focusing training on midwifery also has the benefit of being highly cost-effective due to easier recruitment, better retention, and lower retention and training costs. Moreover, midwives often share closer sociocultural similarities with the women they treat, making them more desirable caregivers in the eyes of patients (Koblinsky et al., 2006). Community-based health strategies promoting the training and implementation of volunteer community health workers, such as Nepal's innovative Female Community Health Volunteer Program, should also be considered. While these programs have been shown to improve maternal and child health outcomes, they are also an efficient source of health information and data, and promote both community development and women's empowerment (Glenton et al., 2010). Considering these alternative forms of training, deployment, and retention may not only strengthen the health care system but also strengthen its relationship with local communities (Koblinsky et al., 2006).

The Government of Kenya has a national responsibility to maintain the financial accessibility of maternal health. It can do so by acknowledging the financial inequalities that exist and proposing health-financing reforms that address them. These reforms must focus on reducing household out-of-pocket costs by enforcing current restrictions on user fees, as well as the "10/20" and free maternal health care policies. Furthermore, the government must consider new options to expand health insurance coverage in Kenya (Bucagu, Kagubare, Basinga, Ngabo, Timmons, & Lee, 2012; Chuma & Okungu, 2011; Lee et al., 2009). NHIF coverage and enrolment must be facilitated through community outreach programs developed in partnership with community stakeholders and delivered through various channels in the community. These programs must focus on raising awareness of, and providing information about the NHIF, and on providing assistance with the enrolment process (Capuno, Kraft, Quimbo, Tan & Wagstaff, 2014; Chuma & Okungu, 2011; Mathauer, Schmidt & Wenyaa, 2008). Key lessons on the impact of health financing reforms can be learned from a review of Rwanda's health policy experiences. In 1996, the Government of Rwanda began developing close partnerships with local and foreign health organizations. These partnerships facilitated the development health financing strategies, which aimed to increase resource allocation to basic health care and promote universal health coverage. These strategies included the introduction of an innovative community-based health micro-insurance ('mutuelles'), performance-based financing, and fiscal decentralization. Nearly 10 years later, these reforms have contributed to a dramatic increase in health insurance coverage and health service utilization, as well as a reduction in out-of-pocket payments among the insured (Sekabaraga, Diop, & Soucat, 2011).

Gabrysch & Campbell's (2009) adapted "three-delay" framework reveals the significant impact of sociocultural barriers on women's access to maternal health services in Kenya, highlighting a significant gap between the cultures of Kenyan communities and the 'culture' of facility-based care. To bridge this highly context-dependent gap, maternal health interventions in Kenya must use a participatory community-based approach, which focuses on eliminating sociocultural barriers to maternal health care by bringing communities closer to health care facilities. Community-based programs, which utilize various community engagement strategies, are a cost-efficient approach to promote healthy behaviours and increase both collective health knowledge and community involvement. Furthermore, they improve attitudes towards and cultural acceptance of medical 'culture' through communication strategies, such as the use of mass media (Lee et al., 2009; PMNCH, 2006). These effects in turn facilitate the development of community empowerment and mobilization – a "… process of enabling people to organize themselves, recognize opportunities, identify their collective potential, and utilize available resources to realize a shared goal through unified action" (Lee et al., 2009, p.4).

Each day, over a hundred women die in Kenya as a result of avoidable complications during pregnancy or delivery (UNICEF, 2014). Gabrysch & Campbell's (2009) adapted version of Thaddeus & Maine's (1994) "three-delay" framework reveals the complex interaction of various barriers that prevent women in Kenya from considering or accessing adequate maternal health care, and ultimately result in these maternal mortalities and morbidities (Gabrysch & Campbell, 2009; Thaddeus & Maine, 1994). In order to slow and eventually reverse this troubling trend, the Government of Kenya must learn from other country's accomplishments and consider new legislative policies to strengthen its health care system, improve quality of care, and ensure the equal distribution of financial and human resources among the counties (Atherton, Mbekem, & Nyalusi, 1999). Furthermore, it is critical that new maternal health interventions are developed upon a participatory community-based approach, involving a close partnership with community leaders and local government ministries (Hussein et al., 2012; KNBS & ICF Macro, 2010; PMNCH, 2012). In the same regard, maternal interventions worldwide must address the unique needs of each community and empower its members to actively participate in the strengthening of local health care systems.

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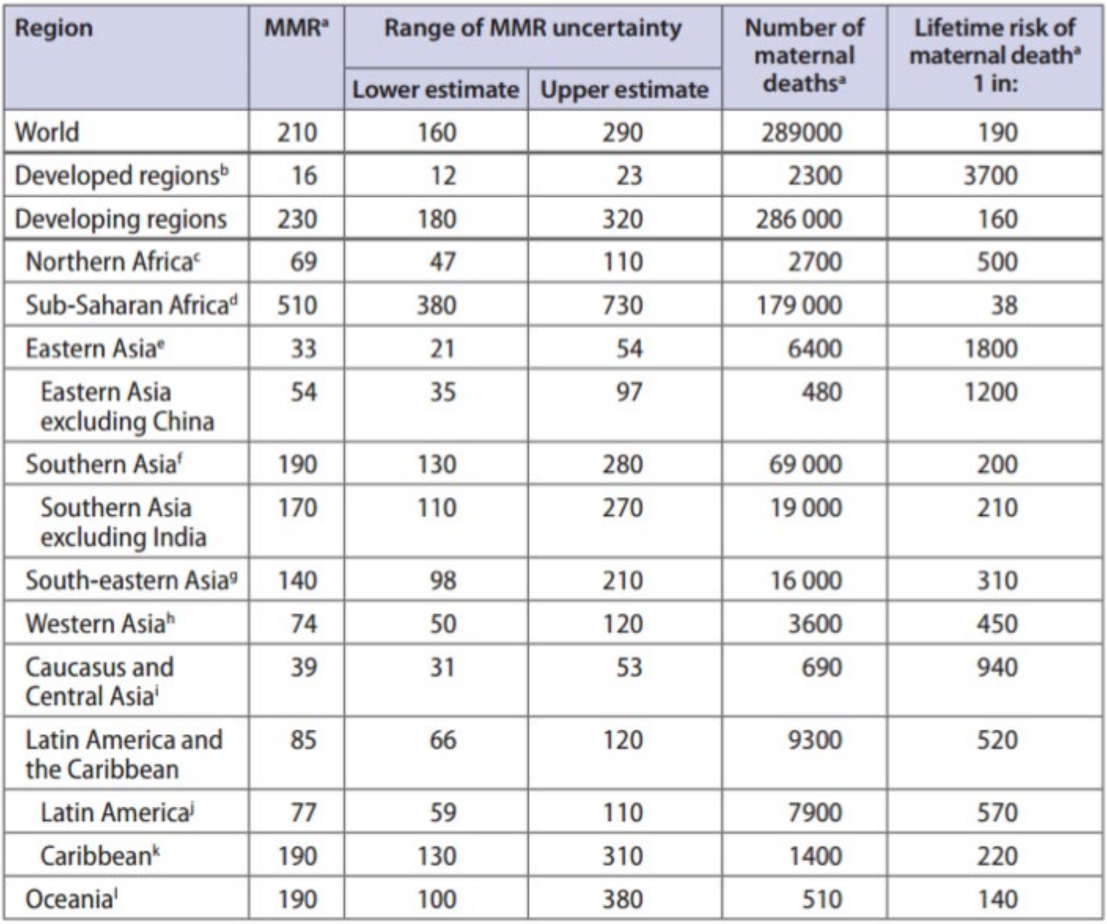
Appendix

Figure 1: Estimates of maternal mortality ratio (maternal deaths per 100,000 live births), number of maternal deaths, and lifetime risk, divided by United Nations Millennium Development Goal regions, 2013. Note the significant disparity in rates of maternal mortality between the Sub-Saharan region and all other regions, as well as the disparity between Developed and Developing regions.



Region	MMR[a]	Range of MMR uncertainty		Number of maternal deaths[a]	Lifetime risk of maternal death[a] 1 in:
		Lower estimate	Upper estimate		
World	210	160	290	289000	190
Developed regions[b]	16	12	23	2300	3700
Developing regions	230	180	320	286 000	160
Northern Africa[c]	69	47	110	2700	500
Sub-Saharan Africa[d]	510	380	730	179 000	38
Eastern Asia[e]	33	21	54	6400	1800
Eastern Asia excluding China	54	35	97	480	1200
Southern Asia[f]	190	130	280	69 000	200
Southern Asia excluding India	170	110	270	19 000	210
South-eastern Asia[g]	140	98	210	16 000	310
Western Asia[h]	74	50	120	3600	450
Caucasus and Central Asia[i]	39	31	53	690	940
Latin America and the Caribbean	85	66	120	9300	520
Latin America[j]	77	59	110	7900	570
Caribbean[k]	190	130	310	1400	220
Oceania[l]	190	100	380	510	140

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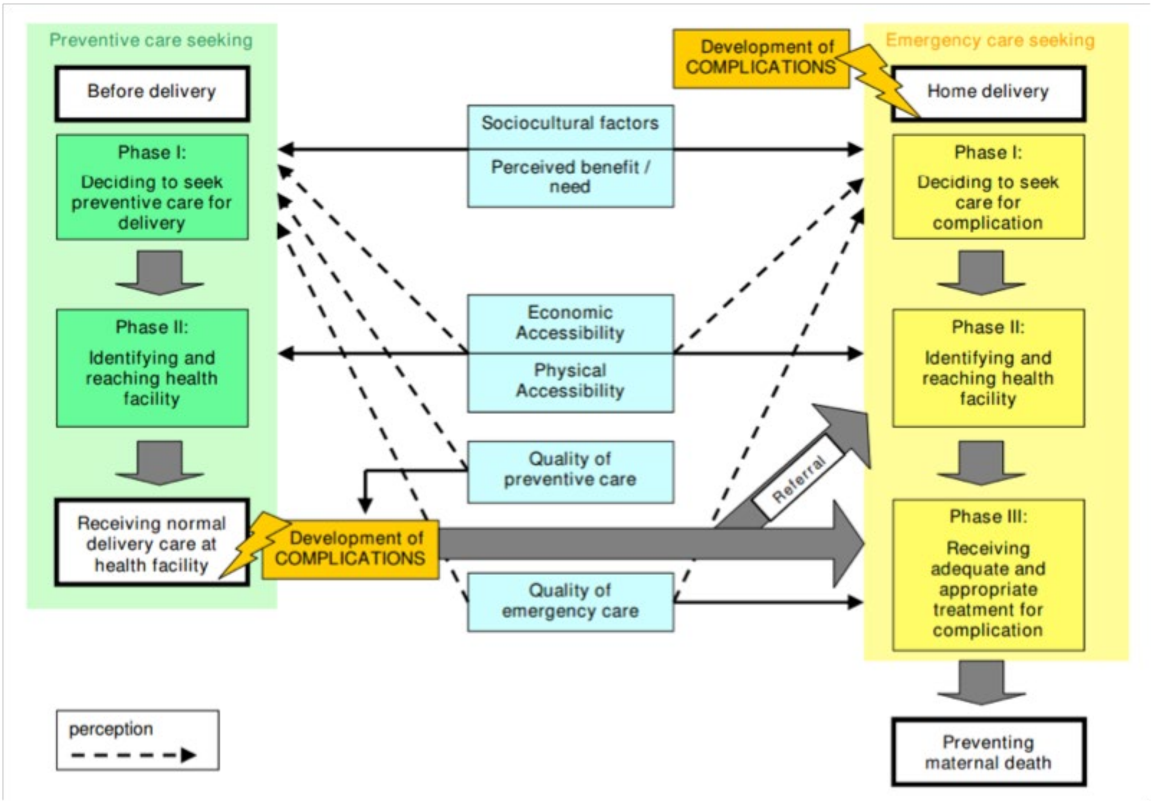
Figure 2: Gabrysch & Campbell's (2009) adapted version of Thaddeus & Maine's (1994) "three-delay" framework. Preventive care-seeking and emergency care-seeking are conceptually separated, with potential barriers located in the centre. Accessing preventive maternal care includes the decision to seek care (Phase I) and identifying and reaching care (Phase II). If a complication arises, a woman's survival will depend on her ability to promptly access adequate and appropriate treatment (Phase III Emergency Care). Accessing emergency maternal care in the event of a complication includes the decision to seek care (Phase I), identifying and reaching care (Phase II), and receiving adequate and appropriate care (Phase III). Successful progress through the emergency care continuum will determine survival. In all phases, delays may result from both perceived and actual barriers.



Gabrysch & Cambell (2009)

Dietary Structure and Relative Health in Inuit Communities

Shariss Ostrager I
McGill University, Montreal, Canada

Abstract

Nutrition is an important contributor to an individual's health. Over the past 50 years, there has been a considerable shift in the diet of indigenous communities, from one which is highly dependent on hunted and gathered food to one that is more reliant on commercial foods. This paper examines the so-called "dietary transition" and the manner in which it has influenced health in Inuit communities. Recent research has shown an increase in consumption of fats from processed foods, which are high in trans-fatty acids, lack key micronutrients found in animals, and contribute to high LDL cholesterol. Consequently, there has been an increase in the incidence of obesity and its co-morbidities, and thus an increase in diet-related chronic disease. Additionally, issues with the dietary transition are compounded for individuals of low socioeconomic status.

Dietary intake has several significant impacts on an individual's health. Most widely acknowledged is the relationship between a poor, energy-dense diet and overweight and obesity (and the subsequent health complications associated with obesity). However, there are also severe health consequences stemming from malnutrition (inappropriate nutrient intake). Technological advances in the production and transportation of food sources have drastically altered the composition of diets in many cultures. In particular, the westernization of indigenous, Arctic communities has resulted in a notable shift in dietary composition over the last 40 to 50 years. Characterized by a decreased reliance on foods that are hunted and gathered in favor of an increased reliance on commercial foods, this mixed diet has subsequently had an important effect on the overall health of Inuit individuals (Jeppesen and Bjerregaard, 2012; Johnson-Down and Egeland, 2012; Sharma et al., 2010;). In light of this so-called 'dietary transition', it is of great value to examine how this adjustment to diet construct has impacted adherence to recommended nutrient intakes and how changes in amount and source of nutrient intake has influenced the overall health in Inuit communities of Northern Canada and Greenland. By investigating what constitutes proper dietary intake, what food types provide these elements, and whether or not these recommendations are being met, this essay explores some factors that influence the ability to achieve dietary adequacy in Inuit communities, as well as the associated health implications.

First, the makeup of an adequate adult diet must be established in order to determine the level of adherence of northern Inuit communities to recommended intake values. The Nordic Nutrition Recommendations (NNR) of 2004 delineate recommended nutrient intakes for normal individuals (lacking uncommon diseases) within Nordic countries. These recommendations serve as a basis to plan a diet that both satisfies nutritional needs (with respect to physiological requirements for growth and function) and enables good overall health, which subsequently decreases an individual's risk of diet-associated diseases (Becker et al., 2004). According to the NNR, the macronutrients in an individual's diet should consist of 15% protein of total energy intake (E%), 55 E% carbohydrates, and 30 E% overall fat (Becker et al., 2004). Additionally, intake of fat should be broken down into the following portions of fat subclasses: 10 E% saturated and trans-fatty acids, 10-15 E% cis-monounsaturated fatty acids, and 5-10 E% polyunsaturated fatty acids. With respect to micronutrients, refined sugars within carbohydrates should not exceed 10 E%, and individuals should consume 25-35 g/d of dietary fiber. Recommended daily allowances for macronutrients and several additional micronutrients are shown in Table 1. Finally, the recommended daily caloric intake for Inuit is 9.6-11.7 MJ/day (approximately 2300-2800 Kcal), with the range accounting for variety in age and sex (Keene, 1985).

		NNR Recommendation		**Non-Nordic Recommendation**	
Macronutrients					
Protein		15 E%		10-35 E%	
Carbohydrate	Refined Sugar	55 E%	10 E%	45-65 E%	<25 E%
Total Fat	**Saturated and Trans-fatty acids**	30 E%	10 E%	20-35 E%	As little as possible
	Cis-monounsaturated fatty acids		**10-15 E%**		..
	Polyunsaturated fatty acids		**5-10 E%**		**5-10 E%**
Micronutrients					
Dietary Fiber		23-35 g		25g	
Vitamin A		700-900 µg		700-900 µg	
Vitamin D		7.5-10 µg		15 µg	
Vitamin E		8-10 mg		15mg	
Vitamin B-6		1.2-1.6 mg		2 mg	
Vitamin B-12		2.0 µg		6 µg	
Vitamin C		75 mg		60 mg	
Thiamin		1.0-1.5 mg		1.5 mg	
Riboflavin		1.2-1.7 mg		1.7 mg	
Niacin		13-20 mg		20 mg	
Folate		300 µg		400 µg	
Calcium		800-900 mg		1,000 mg	
Phosphorous		600-700 mg		1,000 mg	
Potassium		3.1-3.5 g		3.5 g	
Magnesium		280-350 mg		400 mg	
Iron		9-15 mg		18 mg	
Zinc		7-12 mg		15 mg	
Copper		0.9 mg		2 mg	
Iodine		150 µg		150 µg	
Selenium		40-50 µg		70 µg	

***Table 1** shows the recommended daily intake for a variety of macronutrients and micronutrients. Macronutrients are represented as a portion of the total energy intake (%E), and micronutrients are described in units of grams, milligrams, and micrograms. Recommended intakes are shown for those living in Nordic communities from The Nordic Nutrition Recommendations (NNR) of 2004 as well as non-Nordic communities from the US Food and Drug Administration and Health Canada recommended daily intake guidelines (Becker et al., 2004; fda.gov, 2013; hc-sc.gc.ca; Keene 1985; usda.gov). Ranges of vitamin and mineral values account for the variation in needed intakes due to sex and age.*

Through a review of a variety of literature sources spanning several Inuit populations, it appears that the current, typical Inuit diet is composed of a mix of traditional foods and consumer goods. The most frequently reported traditional foods include caribou, fish (particularly arctic char and trout), seal, and muktuk (frozen whale skin and blubber) (Hopping et al., 2010; Jeppesen and Bjerregaard, 2012; Sharma et al., 2010; Sheehy et al., 2013) while the most frequently reported market food items include coffee and coffee whitener, breads, sugars and honeys, sweetened drinks and sodas, butter and margarine, and chips and sweets (Hopping et al., 2010; Sharma et al., 2010). It was found that store-bought foods are typically consumed more frequently than traditional foods (Hopping et al., 2010; Spiegelaar and Tsuji, 2013; Zotor et al., 2012). This is problematic because these purchased foods are energy dense (i.e. highly caloric) and non-nutrient dense foods, meaning they have reduced nutritional value (Hopping et al., 2010; Huet et al., 2012; Jeppesen and Bjerregaard, 2012; Johnson-Down and Egeland, 2012; Sharma et al., 2010; Sharma et al., 2013; Sheehy et al., 2013).

Furthermore, in general, the modern Inuit diet includes an intake of approximately 8-10 MJ of energy (approximately 1900-2400 Kcal), 21 E% protein, 48 E% carbohydrates, and 32 E% total fat (Jeppesen and Bjerregaard, 2012; Sharma et al., 2010; Sharma et al., 2013). More specifically, the breakdown of total fat consists of 11 E% saturated, 12 E% monounsaturated, 5 E% polyunsaturated, and 3 E% n-3 fatty acid. Approximately 40-50% of protein in the current Inuit diet comes from traditional foods (Sharma et al., 2010; Sharma et al., 2013). The largest intake of energy and fat comes from non-nutrient dense store bought foods such as breads and sweetened beverages (Sharma et al., 2010), contributing to 22% of total fat intake, 42-50% of carbohydrate intake, and 73-80% of sugar intake (Hopping et al., 2010; Sharma et al., 2013). This makes sweetened beverages the largest form of sugar intake (Hopping et al., 2010; Sharma et al., 2010). Overall, primary energy intake comes predominately from juice, caribou and game, and bread, providing 25% of daily energy to individuals (Hopping et al., 2010). In addition to macronutrient contributors, micronutrients are mostly acquired through traditional foods. Traditional food contributes to approximately 41% of fiber intake as well as 49% of Iron intake (Sharma et al., 2010; Sharma et al., 2013). They are also the primary source of Vitamin A and Vitamin B-12 (Hopping et al., 2010).

Despite the adequate proportions of macronutrients intake within the present Inuit diet, there is a clear consensus among the literature that there is a lack of several micronutrients. Micronutrients serve many purposes; they contribute to several important bodily functions such as the breakdown of macronutrients and more specifically, the maintenance of growth and vision function from vitamin A (Keene, 1985). As such, it is problematic that certain macronutrient components are being obtained in ill-advised ways. For example, though sugars should contribute to a mere 10% of carbohydrate intake, in actuality they contribute to 42-50%. Furthermore, though saturated fat intake is only moderately higher than the recommended intake within total fat construct, it is preferable for the proportion of saturated fat to unsaturated fats to be minimal (Becker et al., 2004). With respect to micronutrients, fiber, folate, calcium, vitamin A, vitamin B-12, vitamin B-6, vitamin D, and vitamin E levels are all consistently lower than recommended intake values in Inuit populations (Hopping et al., 2010; Sharma et al., 2010; Sharma et al., 2013). Most notably, fruits and vegetables contribute to 27% of total fiber intake. Despite this contribution to fiber intake, it is widely reported that there is still a severe deficiency dietary fiber (Hopping et al., 2010; Huet et al., 2012; Johnson-Down and Egeland, 2012; Sharma et al., 2010; Sharma et al., 2013; Sheehy et al., 2013; Spiegelaar and Tsuji, 2013; Zotor et al., 2012).

In contrast to the current Inuit diet, the pre-dietary transition diet consisted of a far greater intake of traditional foods. Resources primarily included caribou, ringed seal, and fish, but were supplemented by muskox, polar bear, bearded seal, birds, hare, wolf, lemming, squirrel, fox, and some berries (Keene, 1979; Sinclair, 1953). Primary resources were most sought after because they provided more optimal returns in terms of hunting time and energy investments to obtain such resources (Keene, 1979). In addition to food provision from hunter-gatherer activity, some food, including bread, flour, barley, peas, sugar, and coffee, was also acquired through imports from Europe (Sinclair, 1953).

The typical prehistoric diet provided approximately 11 MJ (2600 Kcal) total energy, of which the macronutrient content consisted of 60 E% protein, 11 E% carbohydrate, and 29 E% fat (Sinclair, 1953). This constitutes a dramatically high protein diet as compared to the NNR. However, this issue has been examined and there is seemingly no conclusive evidence that high levels of protein contribute to the incidence of diet-related disease in Inuit (Sinclair, 1953). Overall, the literature is in agreement that the previous Inuit diet, which relied on traditional foods, fulfilled the recommendations for daily nutrient intake and surpassed such recommendations with respect to the majority of macro- and micronutrients (energy, protein, fat, calcium, vitamins A, D, and E, riboflavin, thiamine, and iron) (Keene 1979; Keene, 1985; Kuhnlein et al., 2006; Sinclair, 1953). Calcium, though nutritionally satisfied, was the limiting element amongst all nutrients (Keene, 1979; Keene, 1985). Furthermore, in addition to the required intake of 9.6 MJ (2300 Kcal) of energy per day, hunting activity yielded a surplus of 5.4 MJ/day (1300 Kcal/day) (Keene, 1979; Keene, 1985).

On the whole, a considerable change in diet construct has been observed in Inuit communities. Where diet was once almost entirely reliant on traditional (country) foods, it now consists of a distinguishable mix of traditional and commercial foods and displays a high reliance on non-traditional foods relative to traditional foods (Hopping et al., 2010). In light of this shift to a mixed diet, there has been a consequential increase in the amount of sugary, processed foods (Hopping et al., 2010; Jeppesen and Bjerregaard, 2012; Sharma et al., 2013; Sheehy et al., 2013; Zotor et al., 2012). In particular, fats acquired from game animals have been exchanged for fats that come from processed, store-bought foods, which have notoriously higher amounts of trans-fatty acids (Hopping et al., 2010). Moreover, these processed sources of fat often lack the nutrients such as vitamins A and D that accompany traditional fat sources (Hopping et al., 2010; Kuhnlein et al., 2006). Since both saturated and trans fats have a causative role in increasing serum LDL-cholesterol concentration (Becker et al., 2004; Freeman and Junge, 2005), this kind of fat intake is inadvisable. As the name implies, LDL cholesterol is low density, which allows more particles to occupy a smaller amount of space. This then contributes to the build-up of plaque and formation of blockages in the arteries, which ultimately increases the risk of heart attack and stroke (American Heart Association, 2012; Freeman and Junge, 2005). In addition to the health complications associated with poorly obtained macronutrients, the lack of micronutrients (fiber, calcium, folate, and vitamins A, C, D, and E) that now exists in Inuit diet puts individuals at greater risk of developing chronic diseases such as cancer and other infectious diseases due to compromised immune function (Hopping et al., 2010; Kuhnlein et al., 2006; Sharma et al., 2013; Zadworny, 2014). The relationship between micronutrients and disease is further highlighted by the fact that there was a relative lack of chronic disease experienced under the prehistoric diet regime in which all micronutrient needs were satisfied (Hopping et al., 2010; Sharma et al., 2013).

Additional complications within the contemporary Inuit diet also stem from increasing portion size. Portion size is a major contributing factor to the obesity epidemic and has in fact increased in all foods over the last few decades (Sheehy et al., 2013). Most notably, the portion sizes of sweetened beverages are particularly large at twice the standard serving size (Sheehy et al., 2013). While an increase in portion size is unhealthy, an increase in market food purchases (as is the case with these beverages) is particularly damaging since gross consumption in turn contributes to an increased portion of energy intake in the overall diet (Sharma et al., 2013). The combination of over-consumption and consumption of nutrient poor foods in the present Inuit diet is worrisome. In fact, the effects of the overconsumption of energy dense, nutrient poor foods have begun to emerge. The dangerous combination of increased portion size and decreased nutritional value of foods has contributed to an overall increase in the incidence of obesity in Inuit communities (Sharma et al., 2013; Sheehy et al., 2013). In recent years, an increase in the incidence of obesity in Inuit populations, from 23% in 1992 to 37% in 2004, has been recorded (Sharma et al., 2013; Sheehy et al., 2013). Should this trend in diet continue, it is likely that an even greater increase in the incidence of obesity will be observed.

The effects of obesity are significant as obesity is a precursor to further health complications including cancer, cardiovascular disease, stroke, hypertension, dyslipidemia, Type 2 Diabetes Mellitus, joint disease, and several other conditions and opportunistic infections (Sheehy et al., 2013; Zadworny, 2014). This is problematic because the increased incidence of these chronic diseases will undoubtedly be met with decreased productivity, shortened life expectancies, and increased costs of health care (among many other negative consequences). The outcome of such increased prevalence of obesity is a change in the demographic of diseases affecting Inuit populations, as well as a change in the leading causes of death. While Inuit populations were previously protected from atherosclerotic diseases and diabetes by their genetic isolation, this protection has been disappearing as a result of lifestyle changes such as this observed shift towards a less favorable diet (Bjerregaard et al., 2008). For instance, in the Northwest Territories, between 2005 and 2007, the leading causes of death were cancer (including colorectal, breast, prostate, and lung), followed by cardiovascular disease, and then respiratory disease (Zotor et al., 2012).

In addition to the strain on the body system that extra weight provides, increased body weight is also associated with increased incidence of cancer due to the presence of

Type II Diabetes (Zadworny, 2014). Diabetes causes insulin resistance, which results in higher blood insulin concentration as well as failed removal of glucose from the blood. This is detrimental to the cells because insulin is a mitogen, meaning it stimulates mitosis (i.e. cell division). Further, tumor cells require a high level of glucose as an energy source. Thus, in conjunction with a high level of insulin there is increased proliferation and subsequent opportunity for cell transformation to occur (Zadworny, 2014). This systemic pathway is further supported by the increased incidence of diabetes seen since the 1980s in Inuit communities as well as a shift in the type of cancers occurring in these communities (Bjerregaard et al., 2004). "Traditional" Inuit cancers (including nasopharynx and esophageal cancers) have been declining while "modern" cancers such as breast, colon, and cervical cancers that are common to industrialized societies are rising (Bjerregaard et al., 2004; Friborg and Melbye, 2008). From this information, one might conclude that shifting diet towards consumer foods that are more typical of industrialized societies could be to blame for the change in increased suffering from these emerging conditions as well as the incidence of disease.

Though overweight and obesity levels are increasing in many populations around the world, disease in Inuit communities is especially taxing because the geographic remoteness of these communities makes the cost of treating these diseases particularly high (Sharma et al., 2013; Sheehy et al., 2013). Of additional concern is the observation that the altered dietary composition is more prominent among younger generations, which will have serious implications on future directions of diet quality and respective health (Jeppesen and Bjerregaard, 2012). It therefore becomes ever more imperative to shift trends in Inuit diet towards a more positive direction.

Beyond the increased incidence of diet-related chronic disease markers in Inuit communities, socioeconomic status within Inuit communities also plays a significant role in influencing the nutritional adequacy of an individual's diet. Indigenous peoples experience a "disproportionate burden of food insecurity" compared to non-indigenous counterparts in the same country or region (Egeland et al., 2011). In particular, Inuit populations experience the highest reported incidence of food insecurity for indigenous peoples in North America (Egeland et al., 2011). Food insecurity, which is directly related to poverty, is associated with disrupted eating patterns and decreased dietary quality with respect to nutrient composition (Egeland et al., 2011; Huet et al., 2012). This thereby predisposes impoverished groups to compromised health and diet-related chronic diseases (Egeland et al., 2011). The effects of poverty are further compounded by the progression towards a less healthy, market-reliant diet and the fact that market goods are particularly expensive in the Canadian Arctic (Egeland et al., 2011). Specifically, the preservation and transport of fresh fruits and vegetables (among other items) is quite difficult and expensive, meaning that the quality of fruits and vegetables available is substandard (often frozen rather than fresh) and the extra expenses in providing them are translated into increased prices (Sheehy et al., 2013). As such, consumption of these imported foods such as fruits and vegetables is highest among the wealthy (Jeppesen and Bjerregaard, 2012). Households of lower socioeconomic status on the other hand, consume fewer vegetables and greater amounts of cheaper, high sugar foods (Huet et al., 2012).

Because market foods are expensive and nutritionally inadequate, one might wonder how the Inuit diet could have ever evolved to incorporate less traditional foods and more market foods. This is partly due to the fact that it has become increasingly costly to obtain traditional foods.

The development of a wage economy has left households without hunters and without time to devote to hunting activities. The presence of a male head of household as well as access to an income both increase the proportion of traditional foods found in the diet (Duhaime et al., 2002), thereby decreasing the prevalence of food insecurity and poor nutrition. In fact, it was reported that the chance of having a high vegetable intake is doubled by the presence of at least one employed adult in a household (Hopping et al., 2010; Jeppesen and Bjerregaard, 2012). Further, the cost of hunting equipment is also prohibitively high (Beaumier and Ford, 2010; Huet et al., 2012; Sheehy et al., 2013). In fact, one strategy that has emerged to offset the high cost of hunting is to sell some of the country foods acquired in the practice (Beaumier and Ford, 2010). In addition to the logistics of hunting, Inuit have also experienced a reduction in animal population and a change in migration patterns as a result of climate change among several other factors (Beaumier and Ford, 2010; Sheehy et al., 2013). The challenge of such scarcity of game in conjunction with the increased cost of hunting has led to a decline in the communal food sharing networks that were once present in Inuit communities (Beaumier and Ford, 2010; Sheehy et al., 2013). Overall, it is the combination of reliance on expensive market foods, the purchase of relatively less expensive but less nutritionally valuable items within markets, and increased costs of hunting that has left individuals of low socioeconomic status at a great disadvantage when it comes to achieving the recommended nutrient intakes.

There are several factors that contribute to the relative nutritional status of Inuit populations. The largest influencing factor is the shift from an entirely country food diet to a mixed diet that entails a heavy reliance on high energy but non-nutrient dense foods. However, within the present diet, socioeconomic status has a large influence on ingested nutrients, as it determines what resources an individual will be able to access. Beyond to restrictions on hunting (due to its high cost and the need to participate in the wage economy) and purchasing country foods, those of lower socioeconomic status are burdened by the need to purchase expensive market foods. Thus, in an attempt to budget, low socioeconomic status individuals are likely to purchase relatively cheaper foods in markets, which tend to be of poor nutritional value.

Given the industrial development that is spreading across the globe, it seems likely that markets will retain their presence in Inuit communities. As such, governments should target the provision of better quality foods such as fiber-rich foods such as fruits and vegetables to these stores (Jeppesen and Bjerregaard, 2012; Sheehy et al., 2013). While there has been some acknowledgement of this conundrum at the level of the Canadian government in the form of attempted subsidy programs to provide essential goods, these programs have been found to be ineffective. (Spiegelaar and Tsuji, 2013). Intake of fruits and vegetables, for example, remains an uncommon part of diet in these Inuit communities (Spiegelaar and Tsuji, 2013). As a result, there has been work dedicated to the overhaul of programs such as the Food Mail Program, which partially subsidizes the transportation of produce and other essential goods to northern communities. In fact, the Food Mail Program has been replaced with Nutrition North, which subsidizes food suppliers rather than food transporters (Spiegelaar and Tsuji, 2013). The importance of this work is twofold: first, these programs are important in combating food insecurity, a second, the increased provision of fiber (in the form of fruits and vegetables) can help to protect against obesity and colon cancer because it reduces constipation (Becker et al., 2004).

Similar to recommendations for the remainder of Canada as well as the USA and other countries, it is recommended that the intake of sugar-sweetened beverages be reduced as they are instrumental in weight gain and provide little nutritional value (Sheehy et al., 2013; Zotor et al., 2012). Furthermore, individuals can reduce their intake of saturated fats in exchange for mono- and poly-unsaturated fatty acids by replacing butter and margarine, which are frequently used in sauces, with vegetable oils (Jeppesen and Bjerregard, 2012). One interesting suggestion found among the literature to improve diet quality exploits the popularity of soups and recommends consuming soup as a pre-load before meals to reduce total energy intake. This is expected to be instrumental because soup has a high satiety value and has low energy density (i.e. few calories). Therefore, it is a useful tool to reduce portion size (Sheehy et al., 2013). Finally, additional nutritional education should also be provided to Inuit communities (possibly in the form of leaflets) to help them make informed, wiser decisions about their consumption. For example, Zotor et al. (2012) suggest educating both retailers and home food preparers about the negative health implications of over-consumption of nutrient poor foods as a means to reduce consumption of nutrient-poor, energy-dense foods.

One limitation of Inuit nutrition studies includes the means by which food intakes are acquired. Researchers often rely on the use of food-frequency questionnaires (or other equivalent interview techniques with different names) to determine intake, which is dependent on proper recall and comprehension by surveyed individuals (Sharma et al., 2010; Sharma et al., 2013; Zotor et al., 2012). One study specifically mentioned under-reporting of intakes by individuals as a complication (Johnson-Down and Egeland 2012). Another limitation encountered was poor transparency in the comparison of prehistoric and contemporary diets. Several studies investigated contemporary diets and then qualitatively discussed changes in portion size or the prevalence of market foods consumed but neglected to specifically quantify those changes. Some studies also qualified the benefits of consuming traditional foods by comparing the adequacies of different diets from different individuals in the same generation rather than comparing the overall diet of the current generation to that of the past (Hopping et al., 2010; Jeppesen and Bjerregaard, 2012; Sharma et al., 2013; Sheehy et al., 2013; Zotor et al., 2012). Quantitative analysis of changes in diet with respect to energy and nutrient intake will help to further support the trends experienced and could prove to be an interesting investigation for future research.

Further research in this area could also be conducted to address changes in physical activity. The World Health Organization cites physical inactivity as the “fourth leading risk factor for global mortality” (WHO, 2010). It also addresses the fact that physical inactivity is globally on the rise and that such inactivity has “major implications for the prevalence of non-communicable diseases” including those discussed in this review (WHO, 2010). In light of the decreased hunting activity discussed, change in physical activity could be assessed in terms of its implications on Inuit health. It would be interesting to assess whether the recommendations for energy and nutrient intakes change as a result of changed physical activity levels. If this is the case, it would also be important to reassess the quality of current intakes. Finally, additional studies could also be developed to investigate the implementation and effectiveness of education and nutritional intake programs. Specifically, programs that test the merit of various diet plans will need to address compliance to the diets themselves.

Ultimately, there is great need in Inuit communities for a new dietary transition geared towards consumption of less energy dense and more nutrient rich foods. Current trends in the Inuit diet parallel an increase in obesity and diet-related chronic diseases that are significantly different than traditional diseases. While socioeconomic dynamics remain a challenge, it is imperative to continue work to tackle the dietary transition and its associated health complications.

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Is it still relevant to view health from a cultural standpoint?

Globalisation, cultural dialogues, and suicide in Japan

Sara Perillo I
McGill University, Montreal Canada and
Trinity College, Dublin

Abstract

Cultural health psychology is a field which investigates health behaviours, and which seeks to link those behaviours to the social context in which they occur; globalisation, on the other hand, is a process which allows cultures to come into increased contact with one another. The process of globalisation has been accelerating at such a rapid pace that many wonder whether it will eventually lead to the eradication and replacement of all local cultures at the expense of a single, global culture. If this so-called cultural homogenisation were ever to occur, it may eliminate the necessity of understanding health from a cultural perspective. The present essay will argue, however, that this cultural homogenisation will never truly come to be, and that rather than eliminating local cultures, the process of globalisation instead encourages them to evolve and transform in unexpected ways. The unique status of suicide in Japan will also be examined to make these arguments even more evident. It will therefore be concluded that an understanding of health is necessarily incomplete if culture is not also taken into consideration.

Health is commonly regarded as an absence of signs or symptoms of illness or injury, be they objective (e.g. irregular heartbeat or blood pressure) or subjective (e.g. general feeling of physical or psychological malaise) in nature (Sutton, Baum, & Johnston, 2004). In spite of this, academics agree that this definition of health is too dichotomous to be accurate; illness and wellness are not entirely separate terms, as the definition implies, but rather overlap and exist on a continuum. At the centre of the continuum is a neutral state of being, and at opposite ends of the continuum lie optimal wellness and death (Sarafino & Smith, 2010). Thus, the term "health" refers to "a range of positive states of physical, mental, and social wellbeing – not just the absence of injury or disease – characterised by variations in healthful signs and lifestyles" (Sutton et al., 2004). Historically, health and wellness have been understood from a biomedical perspective, but this approach is limited. It was recognised in the 1970's that psychology and social factors also play a significant role in health, and this realisation allowed for the creation of the field known as health psychology. Health psychology aims to promote and maintain health, prevent and treat illness, identify the causes and diagnostic correlates of health, and to improve health care systems (Sutton et al., 2004). Often, the manner in which these goals can be accomplished varies from culture to culture. Behaviour and thought patterns are affected by the social context in which they occur, and cultural psychology, another field of psychology, seeks to understand precisely how this influence comes about (Bhugra & Bhui, 2007). Culture and psyche indeed merge, and the way by which they influence each other impacts health. Upon this principle is built cultural health psychology, a field which "seeks to describe the diversity of health (and illness) behaviour and link it to the cultural context in which it occurs" (Spielberger, 2004).

With recent innovations in transportation and telecommunication, the pace of globalisation has drastically increased. Globalisation refers to people's subjective experience of the world shrinking as they become more conscious of it. In other words, it is "constituted by the ever-increasing abundance of global connections and our understanding of them" (Barker, 2012), and it allows for the exchange of ideas across countries and cultures to become more and more widespread. Many academics believe that globalisation will ultimately lead to a reduction in cultural diversity so great that all local cultures will be eradicated and replaced by a single global culture. Given the risk of this eventual "cultural homogenisation," it stands to reason that we question the relevance and importance of viewing health psychology through a cultural perspective. However, cultural homogenisation may still not take place: culture and health will remain inextricably linked, and must be understood as such. Furthermore, the process of globalisation may not lead to the elimination of local cultures, but instead encourages each culture to evolve and transform in unexpected and unique ways. To better illustrate these points, recent trends in suicide in Japan compared to "the West" will be examined, and the effect of globalisation on this phenomenon discussed.

The Cultural Homogenisation Thesis

Cultural homogenisation is one of the main characteristics of globalisation. It proposes that "the globalisation of consumer capitalism involves a loss of cultural diversity. It stresses the growth of 'sameness' and a presumed loss of cultural autonomy" (Barker, 2012). More specifically, cultural homogenisation implies the spread of a way of being, "from musical forms, architecture, and modes of dress to eating habits, languages, philosophical ideas, and cultural values and dispositions" (Inda & Rosaldo, 2008).

Some academics hypothesise that cultural homogenisation will result in the establishment of a single global culture, and the eradication of local cultures. Cultural homogenisation is furthermore said to be unidirectional, with the wealthiest and most powerful nations' cultures threatening to shape the others. The world's predominant cultural institutions originated centuries ago in Europe, and nowadays are mostly centred in the United States of America (Schiller, 1991), and so the dynamic spread of cultural globalisation is sometimes described as a Western project (Barker, 2012). Some fear the loss of local cultures at the expense of a Western one, a process sometimes denoted as cultural imperialism. Herbert Schiller, one proponent of this thesis, argues that the "industries that serve as the sites for the creation, packaging, transmission, and placement of cultural messages – corporates ones especially – have grown greatly as their importance and centrality to the corporate economy increases" (Schiller, 1991). Some ancient features of human experience, such as speech, dance, ritual, and music remain vital. However, what distinguishes their situation in the industrial-capitalist era are the "relentless and successful efforts to separate these elemental expressions of human creativity from their group and community origins for the purpose of selling them to those who can pay for them" (Ibid.). Cultural creations, according to Schiller, have been transformed in such a way as to facilitate their commercial production and marketing. With globalisation, it has become possible for these industries to manufacture cultural messages in order to create a "national and international cultural atmosphere", one which has "grown greatly in size, breadth, and productive capability in the years since World War II" (Ibid.). It should be noted that, though Schiller's work is more than twenty years old, his ideas are still relevant; the cultural diffusion has only increased since 1991, aided by communication advancements. For instance, as of June 2012, more than 2.4 billion people were connected to the Internet ("World Internet users statistics usage and world population stats," 2014), representing an increase in users of 566.4% from the year 2000 alone.

In spite of this, many believe that the degree of cultural homogenisation of which Schiller spoke is vastly exaggerated. The global reach of brands and ideas is undeniable, but "their presence alone [need] not signal a deep-seated cultural shift" (Jennings, 2011). The "globalisation as cultural imperialism" argument indeed faces several major difficulties, the most significant of which being that dialogues between cultures have never been unidirectional. So-called "wealthier" and "more powerful" cultures are shaping other cultures just as much as they are being shaped by other cultures themselves. Cultural flows are complex, and not as straightforward as the homogenisation thesis asserts.

Complex Cultural Flows

Cultural discourses always require "interpretation, translation, mutation, adaptation, and 'indigenisation' as the receiving culture brings its own cultural resources to bear, in dialectical fashion, upon 'cultural imports'" (Tomlinson, 2013). Jennings (2011) argues against the idea that homogenisation entails the spread of a single way of life; rather, it is about how people "come into contact with widely shared ideas and products and make them their own." Consider, for example, the legacies South African apartheid: European influence is evident in nearly all forms of South African cultural expression. American-inspired rap music is prevalent and popular among black South Africans, but it is not merely absorbed mindlessly by the South African people. This non-African musical form acquires a South African flavour before it is exported back to the West

(Barker, 2012). It can be argued, then, that in the case of rap music, South Africa influences the United States just as the United States influences South Africa.

Cultural imperialism is a concept that essentially depends on imposition and coercion by one party on another. South Africans, however, listen to rap music and enjoy other forms of Western entertainment by choice. This cultural spread can more accurately be characterized as a form of cultural hybridisation than cultural domination.

Additionally, even if a particular influencing factor interacts with local cultures, each culture will respond to in a unique way. Consider, the worldwide spread of the English language. Due to its prevalence, English words and phrases are often incorporated into different languages, but the degree to which this happens depends entirely on where this language is commonly spoken. The official language of both France and Quebec is French, however, there are more Anglicisms in France French than there are in Quebecois French. One reason may be the confidence of state and cultural institutions in maintaining a minority culture. As Quebec is a French-speaking province in an English-speaking nation, it is hypothesised that French-speaking Quebecois may have more of a reason to protect the so-called integrity of their language than do the French. That not all cultures respond to the same influential factor in the same way is a serious blow to the cultural homogenisation thesis.

It is therefore unlikely that all local cultures are being swallowed and integrated into a single global culture, as the cultural homogenisation thesis suggests. Cultural health psychology's aim of linking people's health (and perceptions thereof) with the social context in which they were raised is hardly a useless or unnecessary pursuit. Globalisation increases the need for cultural health psychology. In order to understand the relationships between globalization and cultural health psychology, we turn to look at culture-bound syndromes and their classification in the Diagnostic and Statistical Manual of Mental Disorders (the DSM).

Culture-Bound Syndromes

A vigorously contested, and potentially extreme, example of the influence of culture on health is the concept of culture-bound syndromes. Culture-bound syndromes are "mental conditions or psychiatric syndromes whose occurrence or manifestation are closely related to cultural factors and which thus warrant understanding and management from a cultural perspective" (Tseng, 2006). For example, taijin kyofusho (literally, interpersonal-relations phobia) is a culture-bound syndrome most common in Japan, but also in China and Korea. This is not surprising, as all three countries share some similar cultural aspects (Ibid.). Taijin kyofusho is an anxiety disorder which involves the patient feeling embarrassed about certain aspects of him or herself (e.g., odour, looks, actions, etc.), ultimately leading to a fear of embarrassing others with their presence. This fear is what distinguishes taijin kyofusho from Western anxiety disorders. Asian cultures tend to place importance on the well-being of the group rather than that of the individual (i.e. these cultures are collectivist, which lies in direct opposition to the individualist tendencies of most Western cultures); these cultural differences allow for anxiety disorders to manifest themselves differently in each culture's populations.

Dealing with these culture-bound syndromes from a diagnostic point of view is controversial. This lies in the representation of culture-bound syndromes in the classification system of the American Psychiatric Association (APA) for abnormal psychology, the DSM. More specifically, the DSM's descriptive nature raises difficulties for classification. Fitting culture-related specific syndromes into the categories of the existing classification system is problematic because many of these are illnesses "defined or manifested by multiple or heterogeneous clinical psychiatric conditions that are difficult to fit under a single diagnostic entity" (Ibid.). Forcing the culture-related syndromes into such a classification runs the risk of losing the unique cultural meaning of the syndromes (Guarnaccia, 1993). Some academics believe this to be a fundamental problem with the DSM; all disorders (not just the so-called culture-related syndromes) warrant a careful cultural consideration to be reflected in the DSM, because all disorders have a cultural component to some degree (Tseng, 2006). Culture-bound syndromes simply have a stronger cultural component than other syndromes. It has indeed been shown again and again that culture can influence health to a great degree, conditioning people to be either particularly resistant or particularly susceptible to a given malady. For example, patients with schizophrenia have been found to experience vastly different symptoms depending on their ethnicity, and these symptoms have been found to correlate very strongly with cultural factors; models of schizophrenia, therefore, now include culture as a significant etiological or protective factor (Brekke & Barrio, 1997).

The DSM was developed in a Western country, but, with the spread of globalisation, is applied to Westerners and non-Western people alike, regardless of their origin. Ignoring cultural factors when diagnosing and treating health problems may be acceptable when every member of the population is exposed to the same social context. Differences in well-being would then likely be due to some cause or variable which varies from person to person (e.g., genetic predispositions, traumatic past events, etc.). But when cultures vary wildly from person to person, differences in well-being may be at least partially due, to cultural diversity.

Therefore, increased globalisation does not render a cultural approach to health irrelevant, as the cultural homogenisation thesis would argue, because globalisation will not wholly eliminate local cultures. On the contrary, increasing globalisation causes different cultures to come into more contact with one another than ever before, which makes apprehending health problems from a cultural perspective more relevant and important than it has ever been. It is indeed not in spite of globalisation that health psychology should continue to be approached via a cultural perspective, but because of it.

Evolution of Syndromes through Time

The tendency of globalisation to bring different cultures together exerts one more force on culture which needs to be appreciated: globalisation causes cultures to transform and evolve in unique and unexpected ways. Even recognised culture-bound syndromes evolve as the "cultural traits or circumstances that contribute to specific syndromes are modified in association with changes in the society" (Tseng, 2006). For instance, the prevalence of taijin kyofusho in Japan has dramatically decreased in association with sociocultural changes occurring in the country (Nishizono, 2005). To better illustrate this notion we can examine the unique form that suicide has historically taken in Japan and how globalisation has affected (but not eliminated) this cultural phenomenon.

In 2009, according to the Japanese Ministry of Health, Labour, and Welfare, 30,707 people (24.4 per 100 000) committed suicide in Japan (Motohashi, 2011). The total has remained higher than 30,000 per year since 1998, thus "posing a serious and urgent challenge for Japanese society" (Motohashi, 2011).

In the West, suicide is currently seen as ipso facto evidence of mental illness (Young, 2002). However, suicide manifests itself somewhat differently in Japan. For instance, the term shinju originally meant a "mutual suicide agreement by lovers in order to prove the genuineness of their love to each other" (Takahashi, Hirasawa, Koyama, Senzaki, & Senzaki, 1998). In recent years, the term's definition has become looser; it now includes a genuine suicide pact, extended suicide (i.e. assisted suicide followed by suicide) and murder-suicide (where one party kills another with whom he or she has close ties before killing him or herself) (Takahashi et al., 1998). What all of these forms of suicide have in common is the feeling of oneness shared by those involved.

Oyako-shinju is a specific category of shinju consisting of parent-child suicide. Most cases of oyako-shinju are boshi-shinju, wherein a mother kills her children before killing herself. Generally, the children involved in boshi-shinju are of preschool age, and what drives the mother to commit such an act are psychiatric disorders and family conflicts. It should be noted that, though the incidence of murder-suicide is similar across cultures, each culture deals with it differently (Ibid.). Arguably, "the important point in studying the relationship between shinju and Japanese culture is not to focus only on statistical analysis and literature on shinju in Japan and other cultures, but to concentrate on the sympathy Japanese have toward shinju" (Aizawa, 1975). Indeed, parents who commit suicide with their children are pitied, rather than shunned, by the Japanese; this may be due to the collectivist nature of Japanese culture (in contrast with the individualist nature of Western cultures). This means that the boundaries between individuals in Japan can be more blurred than in Western societies, where individuality is prized (Takahashi et al., 1998). According to Japanese logic, the mother does not commit boshi-shinju because of any ill-will she harbours towards the child; rather, the suicidal mother believes that no one can take care of her child as well as her, and she would rather kill the child than leave him or her behind in the world without her. She does not see herself as murdering another person, but rather as murdering a part of herself: hence, the Japanese consider boshi-shinju to be a form of extended suicide rather than murder-suicide. It is the collectivist nature of Japanese society that allows for its people to think in this manner. In contrast, Western society considers the child to be a totally separate entity from the mother, and the concept of oyako-shinju or boshi-shinju would not be accepted as a form of extended suicide, but as murder-suicide (Ibid.). In cases where the mother successfully kills her children, but inadvertently fails to kill herself, Western societies would put her on trial for murder. In Japan, the sentence would "likely be light, if any, and more sympathy would be given to the mother" (Ibid.). Oyako-shinju and boshi-shinju illustrate quite well the collectivist nature of Japanese society.

Within the Japanese social context, the act of suicide is a "positive moral act because the values underpinning it are directly related to a socially pervasive moral belief that any act of self-sacrifice is a worthy pursuit" (Young, 2002). In other words, suicide in Japan is not always seen as a denial of the value of life, but as an affirmation of the value of one's moral duty to others (Ibid.). Indeed, in Japanese culture, suicide is a means of taking social responsibility for one's acts. Suicide in Japan thus has a redemptive quality to it. The source of redemption is two-fold: first, it derives its philosophical strength from Confucian teachings about a life of propriety (Ibid.); secondly, it draws on seppuku, a thousand-year-old form of ritualistic suicide performed by samurai who wished to accept responsibility for their actions and mistakes. Seppuku is rarely performed nowadays, but "the values surrounding the act still resonate in the minds of modern Japanese because these values are integral to the Japanese moral ideal of virtue" (Ibid.). Suicide thus becomes another way for the self to be sacrificed for the well-being of the group to which the person belongs (Ibid.).

Japan, then, is an established collectivist society in which suicide is hailed as a moral act of taking responsibility. Globalisation has not changed the uniqueness of the status of suicide in Japan, but it has transformed it in a particular way. The popularity and reach of the Internet have aided the process of globalisation to such an extent that globalisation and the Internet can almost be considered extensions of one another. In this vein, the trend of Internet group suicide in Japan is an instance of globalisation transforming a culture without eliminating its essence.

Internet group suicide is a relatively new phenomenon wherein strangers connect on the Internet and make plans to commit suicide together (Ikunaga, Nath, & Skinner, 2013). Although this form of suicide is portrayed as a "new" trend in Japanese media, it is important to note its similarity to shinju; Internet suicide, too, consists of a small group of people committing suicide together. The difference is that the individuals who commit suicide together via the Internet are complete strangers (Ikunaga et al., 2013). According to one academic, "an anonymous other who is not intimate is a […] stranger. A person who is not anonymous but also not intimate is an acquaintance. A person who is not anonymous and who is intimate is a friend. […] Now, however, we have the intimate stranger, a person who is anonymous but also intimate" (Tomita, 2005). The availability of the Internet thus allows for a new kind of social relationship to form, the paradoxical "intimate stranger", wherein "anonymity becomes the basis for intimacy" (Ikunaga et al., 2013).

The collectivist nature of the society in which they were raised leads to a tendency in Japanese people to seek the comfort of making a group, rather than an individual, decision. Their culture's philosophical and historical legacy leads suicide to be viewed as a morally justifiable and honourable act of self-sacrifice. The country's culture remained the same for hundreds of years, until globalisation and the popularity of the Internet led it to merge with other cultures and, in the process, create a uniquely form of suicide via the Internet. In order to devise an effective strategy for suicide prevention, one must understand and appreciate the social context in which this form of suicide emerged. In this case, a cultural approach to health psychology is necessary, vital, and altogether useful.

Conclusions

The cultural homogenisation thesis states that, as the process of globalisation continues, local cultures will eventually merge to form a single global culture, calling into question the relevance and importance of continuing to approach health psychology from a cultural perspective. However, it is unlikely that cultural homogenisation as such will come to be; globalisation will not make cultural health psychology a meaningless pursuit. In fact, globalisation brings different cultures together to such an extent that cultural health psychology is more necessary today than ever. When a society is culturally homogenous, differences in their well-being may be due to some other aspect of their lives and vary according to the individual. However, unshared cultural upbringings can be reasonably asserted as a cause for differences in well-being. Furthermore, globalisation influences and transforms cultures to transform without losing their uniqueness. Japan's culture remains one of the world's most unique, despite generations of globalisation. A cultural perspective must be employed in order to understand the changing nature of health for people around the world. Cultural health psychology remains a field of importance because of globalisation, and not in spite of it.

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Healthcare for All!

Access to Healthcare for Migrants with Precarious Status in the Parc-Extension Neighbourhood of Montreal, Quebec

Selin Jessa I

McGill University, Montreal, Canada. Research for this paper was carried out under the supervision of Dr. Kevin Manaugh and Dr. Marie-Jo Ouimet

Abstract

Cultural health psychology is a field which investigates health behaviours, and which seeks to link those behaviours to the social context in which they occur; globalisation, on the other hand, is a process which allows cultures to come into increased contact with one another. The process of globalisation has been accelerating at such a rapid pace that many wonder whether it will eventually lead to the eradication and replacement of all local cultures at the expense of a single, global culture. If this so-called cultural homogenisation were ever to occur, it may eliminate the necessity of understanding health from a cultural perspective. The present essay will argue, however, that this cultural homogenisation will never truly come to be, and that rather than eliminating local cultures, the process of globalisation instead encourages them to evolve and transform in unexpected ways. The unique status of suicide in Japan will also be examined to make these arguments even more evident. It will therefore be concluded that an understanding of health is necessarily incomplete if culture is not also taken into consideration.

Immigration rates in Canada are increasing, while Canadian immigration law is becoming more restrictive. Immigrants often arrive through cyclical and forced processes of displacement, and then meet strict immigration regulations at the Canadian border (Walia 2013). The right to health is enshrined as a fundamental human right in the Universal Declaration of Human Rights, but complex Federal and provincial policies govern the eligibility of immigrants for health services and interface with the barriers to integration and accessibility that they commonly encounter (Oxman-Martinez et al. 2005; Sikka, Lippel, and Hanley 2011). A growing and global body of research is documenting the inaccessibility of healthcare for immigrants.

In Canada, the Interim Federal Health Program (IFHP) provides basic healthcare coverage for refugee claimants, victims of human trafficking, and people from moratorium countries. For those denied refugee status, the IFHP covers some health services deemed necessary to treat conditions that pose a threat to public health or safety. In Quebec, the government mandates a three-month wait period upon arrival to the province before immigrants can enroll in health insurance coverage. Once the period has elapsed, new immigrants may be eligible for health insurance through the Régie de l'assurance-maladie du Québec (RAMQ). It is mandatory for residents of Quebec to obtain coverage under this plan if eligible under law. During the waiting period, financial inaccessibility and temporary immigration status prevent many newcomers from seeking insurance from third-party providers. Several immigrant groups are ineligible for Federal health coverage and excluded from care in Quebec, thereby suffering significant health consequences (Ter Kuile et al. 2007; Rousseau et al. 2008; Brabant and Raynault 2012b). That migrants with precarious status experience deleterious health impacts when unable to find safe and affordable care is a recurrent and alarming finding of recent studies, and raises questions about ethics in healthcare practice and provision.
Brabant and Raynault define migrants with precarious status (MPS) as "people born in other countries who, for a variety of reasons, have no legal status [...] because they are neither permanent nor guaranteed" (Brabant and Raynault 2012a:331). Legal dependence on partners or employers, the process and requirements of regularization of status, and the particular circumstances by which immigrants come to Canada also confer precariousness (Ter Kuile et al. 2007; Brabant and Raynault 2012b). Accessibility of healthcare for undocumented and migrants with precarious status varies around the country.

A small group of researchers has investigated the practices of providing care for MPS in Montreal health clinics and healthcare institutions over the last decade. Researchers found that some providers discreetly offer services to MPS, while others turn them away outright (Ter Kuile et al. 2007; Rousseau et al. 2008; Brabant and Raynault 2012a). In several studies, front-line professionals have said that restrictive policies challenge their ability to provide care (Rousseau et al. 2008; Ruiz-Cesares et al. 2013). They note the difficulties of having to work at odds with government policy to meet their ethical obligations as nurses and physicians. Studies have also documented the barriers faced by MPS in accessing healthcare services. Two common themes emerge from the literature. Some barriers relate directly to the lived experience of MPS, including fear of exposure, deportation, or impact on status; physical and geographical accessibility; differing notions of health and wellbeing; and misunderstandings of the system. Other barriers are systemic, and include regulations, administrative complications, and outright racism from care providers (Oxman-Martinez et al. 2005; Ter Kuile et al. 2007; Magalhaes, Carasco, and Gastaldo 2010). Ter Kuile and colleagues note that "problems in accessing care may be largely invisible to those working in the system" because MPS are discouraged from presenting with medical conditions (2007:18).

A key barrier faced by MPS seeking care is disempowerment and misinformation about the healthcare system (Oxman-Martinez et al. 2005, Ter Kuile et al. 2007). Organizations working directly with migrant populations dealing with precarious status, report immediate needs for information regarding available services in order to more effectively carry out their support work (Solidarity Across Borders Montreal 2011). Needed information includes specific services available to various immigrant groups and their costs, availability and qualifications for translation services, referral possibilities, and details of the physical accessibility of a healthcare centre. They also note the importance of having allies in the healthcare system.
This research project aims to explore the accessibility of healthcare in the Parc-Extension neighbourhood of Montreal, Quebec for migrants with precarious status, or MPS, who do not have health insurance coverage. Researchers have conducted extensive legal analysis of how Federal and provincial health and immigration policy intersect with accessibility of care for MPS (Oxman-Martinez et al. 2005; Sikka et al. 2011). This project will focus on how the local application of these policies impacts accessibility of care in Parc-Extension from the perspective of front-line health professionals. Specifically, this study explores two questions:

1. What healthcare services are available to MPS in Parc-Extension? What are the barriers faced by patients in accessing care?

2. What policies and practices govern the accessibility of these services? What are the challenges faced by practitioners in delivering care?

Local Context: Montreal, Quebec

Parc-Extension is a neighbourhood in transformation. Part of the Villeray–Saint-Michel–Parc-Extension borough, it is home for approximately 31,000 residents (CDEC 2004). 62 per cent of these residents are born outside of Canada, which is more than twice the average for the city of Montreal (CDEC 2004). Little data exists about the situation of MPS in Parc-Extension specifically; however, about 20,000 to 50,000 undocumented migrants are estimated to be living in Montreal, excluding other categories of legal but nevertheless precarious immigration status (Brabant and Raynault 2012b; Magalhaes et al. 2010).

The local health authority, the Health and Social Services Centre (CSSS) de la Montagne (one of 12 across the city) directs institutional health services in Parc-Extension. The neighbourhood is served by the Local Community Service Centre (CLSC) Parc-Extension, three private clinics, and La Maison Bleue, a family medicine group and non-profit organization affiliated with CLSC Parc-Extension that offers perinatal services. Immigrants in Parc-Extension are also supported by a number of community organizations, which range from youth and neighbourhood associations to migrant support groups. Of note, Solidarity Across Borders is a migrant justice network that supports migrants and their families around Montreal. Médecins du Monde, an international humanitarian organization, also operates Projet Montréal, a mobile clinic staffed by health professionals that provides services including referrals and mental healthcare to immigrants without health coverage in the city.

Studies in Montreal have explored accessibility of care for migrants, but to date no collaborative research assessing the availability and accessibility of formal healthcare services for MPS has specifically focused on the neighbourhood of Parc-Extension. Cuts to Federal-level coverage in 2012 and a recent temporary expansion of the Interim Federal Health Program underscore the need for more current assessments of accessibility of care for MPS groups in the city.

Methodology

Two important concepts guided this research. First, this project seeks to use a community-based and participatory approach. The research questions were developed in collaboration with local community organizations and informed by local needs. The study was focused on a single neighbourhood in hopes of identifying locally applicable policy recommendations. Second, I acknowledge that there exist underlying systemic causes of inequitable access to healthcare including unequal power distribution, racism, and classism; and that people experience intersecting forms of oppression (Walia 2013; Minkler and Wallerstein 2008; Willen, Mulligan, and Castaneda 2011). These cannot be addressed in this methodology.

This project was conceived based on a briefing from Solidarity Across Borders obtained through the Community-University Research Exchange, which identified information about health services needed in order to better support migrants in the city. Following a literature review, research questions were identified in collaboration with members of Solidarity Across Borders and Médecins du Monde. Approval of the ethical acceptability of the research was received from McGill University (McGill REB File #156-1014) and SHERPA, the research centre of the CSSS de la Montagne.

Most participants were identified using the snowball sampling method. A list of clinics existing in Parc-Extension was also obtained from the CSSS, and where individual front-line health professionals had not already been identified through snowball sampling, clinics were telephoned. Of the five clinics operating in Parc-Extension, the three private clinics declined to participate. Three interviews were conducted with front-line healthcare professionals at the two remaining clinics. The participants included a family doctor at the CLSC and two social workers at La Maison Bleue. Prior to each interview, informed consent was obtained, as well as consent to record the audio of the interviews. Responses were analyzed, common themes were identified, and critical discourse analysis was then applied. Finally, local solutions and opportunities for further research were identified.

Results: the state of access to care for MPS in Parc-Extension

This study sought to analyze the status of access to healthcare in Parc-Extension for uninsured MPS by interviewing front-line care providers in clinics in the neighbourhood. Two clinics participated in the study. CLSC Parc-Extension, the local network clinic, houses a number of services including: an appointment-based ambulatory clinic, a walk-in clinic, vaccination services for children, and a chronic illness clinic for patients with conditions including diabetes and hypertension. La Maison Bleue (LMB) is a family medicine group of the CSSS de la Montagne as well as a non-profit organization, which offers perinatal services for women who meet certain vulnerability criteria and medical and social services to their families. Findings from interviews with participants at these clinics are presented and discussed below.

Availability and accessibility of services

A primary objective of this work was to meet local needs by cataloguing the health services available to MPS without coverage in Parc-Extension. At both clinics where front-line healthcare professionals were interviewed, MPS without a RAMQ card and documents proving IFHP eligibility and coverage were accepted for care based on varying criteria. In Table 1, the responses of participants regarding eligibility of uninsured MPS are presented alongside conditions and accessibility details.

Table 1: *Services available for MPS in Parc-Extension*

Clinic	**Eligibility of MPS without coverage for services**	**Accessibility details**
CLSC Parc-Extension	Patients without documents accepted during walk-in clinic only	• Walk-in clinic hours: 9 a.m. – 12 p.m. Tuesday & Friday, 9 a.m. – 3 p.m. Wednesday (as of February 2015) • $100 cost per consultation • Translator not available for walk-in consultations
La Maison Bleue Parc-Extension, family medicine group	Patients without documents not accepted, except in limited situations	• Patient must meet vulnerability criteria • If criteria met, MPS without coverage generally only accepted when unable return to country of origin • $160 cost for blood test; additional costs for tests such as ultrasounds • Cost for hospital delivery via payment plans • Translation services available

At the CLSC, uninsured patients are accepted and directed to present during walk-in hours. MPS can then consult with a health professional (a physician, nurse, social worker, nutritionist, et cetera) at a cost of $100 per visit. Uninsured MPS cannot book appointments. One doctor noted that because patients without coverage are only eligible to be seen during walk-in clinic, the availability of a doctor depends significantly on physicians' own decisions to dedicate hours to accepting walk-in patients. As well, because they are only available when booked in advance, uninsured MPS facing language barriers cannot readily access translation services at the healthcare institutions.

At LMB, where services are free to patients through its association with the CLSC as a family medicine group, undocumented patients with precarious status are generally not eligible for the services offered except in specific cases. In Quebec, RAMQ may cover healthcare services related to pregnancy only for pregnant women eligible for RAMQ and waiting for coverage to take effect following the three-month waiting period. In this case, LMB will assist the patient in preparing the appropriate documents explaining their situation should care be required elsewhere (delivery at a hospital, for example). For MPS who fall between the cracks of provincial and Federal coverage, should they meet the SIPPE vulnerability criteria, LMB may accept to see them free of charge, save for costs for blood tests and ultrasounds. Participants interviewed at LMB also noted that for pregnant MPS without residency or insurance papers, they would work to make appropriate referrals for care options, to Médecins du Monde, for example. Hospital fees, however, are separate from the services offered by LMB; for MPS, LMB does not cover costs of delivery and would assist pregnant women in making payment arrangements with a local hospital. One participant noted that monthly payment plans are often arranged, because if payment plans were not established prior to entering into a doctor's or midwife's care at LMB, the costs for delivery would be billed to the clinic, which they are unable to bear.

Barriers faced by migrants with precarious status

Participants from both clinics identified certain accessibility barriers for MPS. A common barrier was financial costs to patients; the doctor interviewed at the CLSC explained that the $100 cost to see a medical professional is charged on every visit, and any prescription medications, referrals, or hospital visits could have further costs. This doctor noted that costs to both patients and the care providers impact the level of care: depending on the clinic's relationship with the pharmaceutical provider, they may need to rely on sample medications and can therefore only prescribe reduced drug regimens. At LMB, cost was a less salient limiting factor; the on-location services were provided mostly free of charge through CLSC funding.

When probed about a representative story of the barriers faced by MPS in Parc-Extension, one participant described a woman who came to Canada from a Caribbean country, gave birth here, and has been living in Canada for more than twenty years. Though her son was able to gain regularized status, she has never submitted an immigration application, and as a result has been unable to properly obtain medication regimens and on a broader level, improve her employment situation or access child support systems. The participant explained that she is worried about penalization or deportation by immigration authorities should she begin the process of attaining Canadian residence status. Commenting more broadly on detention and deportation of undocumented migrants in Montreal, the participant noted the links to deeper issues of systemic racism in Canadian society. Criticizing the use of terms like "illegal immigrant" by government officials and in immigration policy documents, they asserted, "It feeds racism and bigotry, and it doesn't make our work any easier."

A final barrier that participants identified as impacting MPS' access to healthcare services in Parc-Extension was patients' misunderstandings about the healthcare system. Many MPS are unaware of the care to which they are entitled. This issue is especially prevalent following changes to coverage eligibility (e.g. the 2012 cuts to IFHP coverage) when the usefulness of formal communications by mail is contingent on whether the recipient speaks French or English or whether they can find a member of their community who could translate. Participants also raised the issue that MPS, particularly undocumented immigrants, fear disclosure of their status to immigration authorities should they access care. All participants were adamant that confidentiality was of the utmost importance in their practice and that accessing care would have no impact on the status of the immigration application for a patient seeking regularized status. One participant mentioned that administrators were often willing to “look the other way” when physicians provided care for undocumented migrants.

Experiences of front-line health professionals

The healthcare professionals interviewed in this study were asked to speak about their experiences caring for MPS. Participants’ professional backgrounds varied: one participant had worked at their clinic for over a decade, a second had been practicing as a social worker in Montreal for twenty years, while the third participant was completing her training at the time of the interview. Participants all believed that migrants with precarious status do deserve equal and equitable access to healthcare services. They discussed challenges they encountered in their practice and how these impacted what services they could actually offer.

A major barrier specific to the CLSC was that physicians could not access funding for the care of uninsured MPS. This forces providers to narrow services for the essential and affordable, and impedes their ability to provide consistent follow-up to patients, meaning they are unable to carry out what they feel is their professional responsibility. As a consequence of these limitations, one doctor explained that physicians must carefully evaluate whether the seriousness of a condition that a given precarious-status patient is suffering outweighs the potential costs to the patient for the procedure, test, or treatment needed. This issue has worsened with increasingly limited financial resources. Participants also described how available clinic resources impacted their ability to personally negotiate on behalf of a MPS for direly-needed procedures or services. They commented on both the difficulty of finding allies in the healthcare system and their inability to advocate for every patient to a level that would guarantee them the care that they need. All participants and informants agreed their work was made more challenging by cuts to funding for health services by the provincial and Federal governments.

According to those interviewed, where participants worked had an impact on health professionals’ experiences of caring for MPS. When asked about professional resources specifically available to overcome cultural barriers between patients and care providers, one participant noted that some workshops on cultural awareness were provided by SHERPA, the research branch of the CSSS de la Montagne, which has a research axis dedicated to studying experiences of immigrants accessing care in the region serviced by the CSSS. One participant believed that they learned from the experience of working with patients of various cultures because they encountered MPS so often, and another participant felt that in her place of work, administrators tried to deliberately foster an open-minded attitude toward immigrants. Participants agreed that issues of cultural sensitivity, while present, were much less prevalent than they have been previously, attributing this improvement in part to such resources and efforts.

Solutions and opportunities

All participants were asked about their perspectives on possible solutions to the issue of access to healthcare for MPS. Responses varied from community-level leverage points to changes in provincial and Federal health policy to societal change. At the local level, it was suggested that having dedicated translators at clinics could tackle language barriers when translators from the BII couldn't be arranged for walk-in patients. Participants also noted the value of resources such as trainings on cultural awareness. One participant suggested that these be made mandatory for new physicians, particularly in regions such as Parc-Extension that is home to large immigrant communities. It was also suggested that professional organizations such as the Fédération des médecins omnipracticiens du Québec (FMOQ, the Quebec Federation of General Practitioners) could play a role in disseminating best practices of care for MPS to their members. Finally, participants were in consensus that changes in immigration policy to extend coverage to excluded groups and to facilitate the process of regularization of status continue to be important goals for advocates.

Discussion

Various researchers have worked to catalogue the availability of healthcare services for migrants without status, examine attitudes among healthcare professionals toward providing care for MPS, and understand barriers faced by these populations in accessing care. In this study, I aimed to conduct a comprehensive exploration of accessibility of care within one Montreal community, examining (1) the available services, and (2) the context of policy, practice, and professional attitudes within which these services are offered. Throughout the study, emphasis was placed on community participation through collaboration with Solidarity Across Borders, a migrant justice network in Montreal. In this section, the data is discussed and situated in the context of the Parc-Extension neighbourhood as well as broader Canadian society.

The first goal of this study was to catalogue public health services in Parc-Extension. It was found that care free-of-charge is generally not available to MPS. At the CLSC, migrants without any health insurance or coverage are charged for every visit, while at LMB, MPS must meet certain vulnerability criteria to receive free services, which are focused on perinatal care. These results and responses of participants support findings of numerous studies that a financial burden exists and discourages MPS from seeking care (Ter Kuile et al. 2007; Brabant and Raynault 2012b; Brabant and Raynault 2012a; Magalhaes et al. 2010). Where services are offered to MPS, they are often provided discreetly or as a result of personal negotiation by healthcare professionals on behalf of patients – a situation that has also been demonstrated in other studies (Rousseau et al. 2008; Ruiz-Cesares et al. 2013). Aside from cost, the other barriers to care that participants felt MPS experience include: discrimination by health practitioners, lack of knowledge about coverage of healthcare, and fears of disclosure of their information to immigration authorities, especially where there exists a possibility of detention and deportation. These data reaffirm many previously identified barriers including delayed and denied care (Magalhaes et al. 2010) and obstacles arising from restrictive regulations and burdensome administrative requirements (Ter Kuile et al. 2007).

The second objective of this study was to explore the local policies and practices that govern the accessibility of health services for MPS. In most clinics, little written policy exists on care provision for undocumented and uninsured immigrants. At the provincial and Federal levels, however, the literature has suggested that policy and regulations restrict care provision (Oxman-Martinez et al. 2005; Sikka et al. 2011). I identify several factors that influence the care that front-line workers provide to MPS: healthcare providers' personal experiences, access to professional resources, and their ability to negotiate on behalf of a patient when services at other institutions (e.g. hospitals) are required. In some cases, participants felt forced to provide substandard care due to these difficulties, and noted negative health consequences for patients. Overall, these findings corroborate other studies documenting challenges and attitudes of health professionals (Ter Kuile et al. 2007; Rousseau et al. 2008; Ruiz-Cesares et al. 2013; Magalhaes et al. 2010; Vanthuyne et al. 2013).

Discursive analysis of participants' comments yields a number of observations. Comparing responses from the participant from the CLSC with responses from caregivers at LMB, the former was more likely to identify and describe challenges to the practice and to speak against the broader societal and policy-related issues that impact immigrants' lives. In contrast, LMB workers placed a greater emphasis on maintaining stakeholder and institutional relationships with the CLSC and hospitals in particular. This could be attributed to the fact that LMB also operates as a non-profit organization. Comparatively, because LMB is dedicated to providing perinatal care for vulnerable women, some of the challenges faced by physicians at the CLSC (e.g. cultural barriers) may have been already addressed through practices in place at LMB to meet needs that arise from working with vulnerable populations on a daily basis.

Some inferences can be made about the value systems of the participants. Participants were all generally in favour of more equitable access to care for MPS. Whether or not they were regular-ly able to provide care for MPS, they all agreed that expansions to provincial and Federal coverage are needed. While participants from LMB placed a particular emphasis on empowerment of patients, nearly all stories and examples that participants recalled "morally orientated" the listener toward empathy with the immigrants who were the subjects of their stories and recognition of injustices within the healthcare system (Hastings 1998:198). Notably, this is not entirely consistent with more expansive studies of healthcare workers where beliefs have been expressed that health is a privilege of citizenship as opposed to a human right (Ruiz-Cesares et al. 2013; Vanthuyne et al. 2013). This is potentially attributable to a bias that exists among the participants due to use of the snowball sampling method. Participants were recruited from informants knowledgeable about the subject of access to care for MPS and it is likely that the participants contacted had a similar knowledge base. It is also worth noting that all participants were employees of public health clinics, since the three private clinics contacted during participant recruitment declined to participate. Furthermore, healthcare providers at volunteer-run clinics such as Médecins du Monde, and other community and alternative health services, were not included in this study.

Methodology: reflections and limitations

Throughout this work, I emphasized a collaborative research process in the hopes of creating useful and applicable knowledge that could improve the accessibility of care for MPS in Montreal and tackle the disempowerment often identified as a barrier. This study sought to provide information regarding the accessibility of healthcare services in Parc-Extension to those that support MPS, including migrant justice groups and volunteer clinics. For two clinics in the neighbourhood, this was achieved to some degree. Responses from participants, however, indicate that different services may be subject to different costs, and that some groups of MPS may be accepted for care while others may not. Furthermore, the practices and policies in private clinics in the neighbourhood are unclear. This yields an incomplete picture of what services are available, and highlights the need to document who can access healthcare in Parc-Extension, the cost of individual services, and accessibility information such as translation services, physical accessibility of buildings, methods of payment, hours of operation where they differ from regular clinic hours, and geographic location. A detailed catalogue of services could be developed through a more structured interview or survey format. Such a research objective must also contend with how to accessibly present findings so that they may be useful to immigrant communities.

An inherent limitation also exists because of who was consulted in developing this profile of available care for MPS in Parc-Extension. Although this work is grounded in an attempt to speak with and not for MPS, certain voices were not directly included here: namely, migrants confronting precarious status. Cognizant of a history of exploitative research of vulnerable populations (Minkler and Wallerstein 2008), along with my inability to provide compensation to MPS and address any psychosocial concerns that could arise in speaking to them about issues of health and accessibility, in this preliminary study, I sought to avoid token inclusion of immigrants in the participant base. Instead, this project works toward meeting the urgent needs identified by research partners who do work directly with MPS. A consequence of this may be a narrow portrayal of immigrants' lived experiences that does not explore immigrants' agency, self-determination, resilience, and successes in overcoming the barriers identified here.

Finally, it should be noted that while a consensus was observed among participants that racism and discrimination make care difficult to access for immigrants, this methodology did not achieve more than a cursory exploration of how issues of systemic oppression impact immigrants' experiences. Many researchers have described how notions of citizenship, construction of some groups of migrants as "illegal," restrictions to regularization of status, and criminalization of these populations result in the hierarchization of identities in Canada, and impact the lives of newcomers (Walia 2013; Ter Kuile et al. 2007; Magalhaes et al. 2010; Brabant and Raynault 2012b). By extension of this framework, critical discourse analysis could be directly applied not just to participants' responses, but more broadly, beginning with perceptions of a 'universal' Canadian healthcare system, and then analyzing societal narratives and public discourse about immigration, vocabulary in research exploring immigration, and language use in government immigration policy documents (Ruiz-Cesares et al. 2013; Willen, Mulligan, and Castaneda 2011).

Future directions: toward more accessible care

This study employed a participatory, community-based research methodology to lay the foundations for a catalogue of health services available to migrants with precarious status in Parc-Extension, identified barriers faced by immigrants in the neighbourhood in accessing care,and explored related challenges that professionals face in two Parc-Extension clinics.

From the results of this study, three actionable research directions have been identified as important for extending this analysis and improving the accessibility of services in Parc-Extension. First, available services and their accessibility information should be more fully catalogued in the neighbourhood, and allies should be identified in the healthcare system: health professionals who could assist workers at community organizations in supporting the migrants with whom they work and organize. Second, professional resources should be designed to support physicians and front-line care providers in working with migrants with precarious status, and training around migrant care issues should be implemented. Third, epidemiological research to better understand the health impacts of inaccessible care should be undertaken.

Precedents such as the "Access Without Fear" policy in Toronto, underscores the possibility of transitioning to equitable and enabling healthcare systems in Canada. Taken together, the findings of this study highlight the need for further local research to better understand the situation of precarious-status immigrants in Montreal, and to strengthen the case for changes to provincial and Federal health as well as immigration policy.

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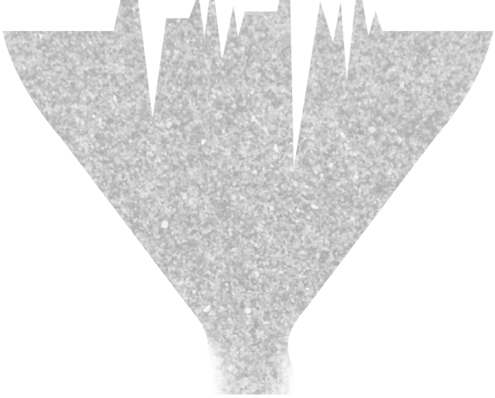

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