Intercultural Approach: A Current Need

Part 1: Profile of the Condition of Immigrants in Quebec and the Challenges They Face

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"Yet, he is never simply torn between here and elsewhere, now and before. Those who believe they are crucified in such a fashion forget that nothing ties them there anymore, and, so far, nothing binds them here. Always elsewhere, the foreigner belongs nowhere."[1]

Julia Kristeva

Introduction

Due to its file size, this document has been divided into three parts. The first section provides general information on interculturalism, care and the role of the nurse in this context. Basic and essential information is also provided on the migratory process, on potential adaptation methods for immigrants, and on how to get to know this clientele better. This section also provides a realistic outlook on the health condition of newcomers, their origins, their level of education, their average age, and so on.

Culture is the set of social structures and intellectual, artistic and religious expressions bound by common language, values, traditions and lifestyles which define civilizations or societies in relation to each other.

Immigration is a challenge to which we must adapt

Julie Lee. ***Escape to Freedom: The Journey of Hanah Lining***.

Within the context of globalization and the changing demographics in our province, nurses must adapt to the phenomenon of immigration, which is not entirely recent but which is playing an increasingly important role in our society. Care centres, in particular in big cities, have become cultural mosaics which require flexibility on the part of attending care providers. Mikhaël Elbaz noted that the migration of people is a phenomenon which is intricately tied to the destiny of mankind. "[Migrations] have constantly modified the make-up of nations," just as they have the dynamics of our services, thereby encouraging us to become more receptive.[2] Indeed, cultural factors differ in diverse and far-reaching aspects, including among practitioners and clients in areas such as language or accent, skin colour, and so on. Health care organizations and personnel must rise to the occasion to deal with these challenges effectively.

[1] Kristeva, Julia (1994). *Strangers to Ourselves* (L. Roudiez, Trans.) New York: Columbia University Press, 11 (Original work published 1988).
[2] Elbaz, Mikhaël. Presented at the *La migration, constante de civilisation* [conference]. Retrieved on May 22, 2009 from http://www.cerium.ca/La-migration-constante-de.

Multiculturalism or interculturalism?

The first question we face is: should we encourage the use of the term multiculturalism or of the term interculturalism? In the May 9, 2008 edition of *Le Devoir*, Charles-Antoine Sévigny wrote: "[TRANSLATION] We first saw the emergence of the multicultural model, which aimed to establish fair and just relations among cultural groups. Multiculturalism, however, has been criticized for leading to the isolation and ghettoization of cultural groups. There is now a complete backlash against the use of the term *multiculturalism*."[3] As a result, *interculturalism* is being increasingly used.

Interculturalism provides another trove of profound values which can inspire us to detect and accept unique cultural aspects among our immigrant clientele and to engage in a professional dialogue in a spirit of mutual recognition and respect. In a sense, interculturalism is a *social contract* which can be extended to other social areas, not just health care.

Care which recognizes intercultural needs

Without slipping into the senseless issues raised during the debate on reasonable accommodations, we must be willing to listen to these patients as we would others because they are extremely vulnerable. We must help them understand the health care system and provide assistance in their difficult process of adapting to our values regarding health care, prevention, pregnancy, birth, childcare and treatment. We must also support immigrants in their integration without diminishing their individual identity in what would result in a fruitless acculturation process for both parties.

Cultural competence is defined as "developing an awareness of one's own existence, sensations, thoughts, and environment without letting it have an undue influence on those from other backgrounds; demonstrating knowledge and understanding of the client's culture; accepting and respecting cultural differences; adapting care to be congruent with the client's culture."

Source: Purnell, L.D., and Paulanka B.J. *Transcultural Health Care: A Culturally Competent Approach.* Philadelphia, Pa: FA Davis; 1998:1–7. Retrieved on May 22, 2009 from http://ccn.aacnjournals.org/cgi/content/full/24/4/48.

To face the massive influx of immigrants into our health care services, we must first understand this vulnerable clientele and then implement measures which are adapted to their needs. Throughout history, nurses have been at the frontline of medical and technological innovation and at the forefront of social evolution. The current trend requires that nurses have intercultural competence to deal with the needs of immigrant communities.

Acquiring intercultural competence means developing an approach which reaches out to immigrants in matters governing their physical and psychological needs and which leads to the development of intervention strategies which are acceptable to them. That being said and in spite of outstanding efforts, care providers are not always attentive or receptive to the needs of immigrants. This may be the result of lack of awareness of the needs of immigrants living in big cities, of the conditions often faced by newcomers, and of a few unfortunate stereotypes. It is therefore

[3] Sévigny, Antoine (2008, May 9). Multiculturalisme - Vers un renouvellement de l'interculturalisme québécois. *Le Devoir*. Retrieved May 22, 2009 from http://www.ledevoir.com/2008/05/09/188897.html. This article is referred to in the Annual Report of the Canadian Multiculturalism Act 2006-2007, retrieved on May 22, 2009 from http://www.cic.gc.ca/multi/rpt/104-fra.asp.

desirable that professionals adapt to the current situation; however, that cannot happen unless they first demonstrate interest in the general reality of immigrants, in particular their values, cultures, lifestyles, health care needs and backgrounds. These realities also include aspects which make immigrants vulnerable as a result of their ethnic origin or refugee status. These adaptations are necessary if we are to provide better services to our immigrant clientele.

Intercultural competence implies that nurses work with immigrants with compassion and dignity, and that they respect the uniqueness of each individual.[4] But what does this entail? Such competence undoubtedly involves facing challenges in order to understand their beliefs and lifestyles, and the occasional destabilizing confrontation with our scientific and more modern health care methods.

The Migratory Process

There are many stages involved in immigration

- **Pre-immigration phase:** Occurs before leaving to the immigration destination; involves preparations fot the volontary or forced departure; social and emotional disruption.
- **Emigration:** The actual trip and arrival en the new homeland, culture and climatic shock.
- **Post-immigration phase:**
  - Settling down, searching for lodging and work;
  - Awareness of social, cultural, languistic and other differences;
  - Adjustement to local value and custums;
  - Integration: Adopting new values and behaviours.

Requirements of intercultural care and the migratory process

Intercultural care basically requires a certain understanding of the migratory process and its stages. We must acknowledge that immigrants are often displaced persons with a past, sometimes normal, but all too often marked by misery, war, and violence. These events often affect or interfere with their adaptation to their host country. Fear and suspicion are often part of their baggage when they arrive in our country. This is the **pre-immigration phase**.

The need to choose between former and new customs may lead to four different adaptation modes:

1. **Assimilation: Abandonning one's cultural identity and blending into the majority (i.e.: U.S. *melting pot*);**
2. **Integration: Remaining true to one's original culture while adopting certain social customs of the dominant group (i.e.: Canada's *cultural mosaic* model);**
3. **Separation: Self-imposed withdrawal from the dominant social group while maintaining one's original cultural identity;**
4. **Marginalization: Rejecting the dominant social group and the values of one's original culture; dissolution of the original cultural identity.**

This is when immigrants prepare to emigrate. Each immigrant has a unique trajectory. For some, the departure has been thoroughly planned and is desirable; for others, it is suddenly forced upon them as a result of natural disasters or political upheavals in their homeland. This is the plight of economic immigrants and refugees.[5]

[4] American Nurses Association. (2001). *Code for Nurses.* Washington, DC: ANA Publishing.
[5] Ungureanu, Adina. (2007). *Le Parcours migratoire et la santé mentale des aînés immigrants* [PowerPoint presentation]. Retrieved on May 22, 2009 from http://www.accesss.net/documents/File/Parcours%20migration%20final.ppt.

The second stage of this process is the actual **immigration**. The immigrant leaves his homeland, arrives in his new country and faces new challenges. This stage mainly involves comfort or misery during the trip, administrative hurdles and culture shock.

The third, **post-immigration phase** involves **settling down**, and becoming aware of social and cultural difficulties, and adapting to local standards and customs. Finally, after a long period, the fourth stage, **integration** to the host country occurs. Immigrants then find balance in their lives. They continue to maintain many aspects of their culture, but are aware of the distance with the values and customs of their homeland. In this stage, the immigrant adopts certain values and customs of his host country and is capable of living in harmony in his new land. It is essential to avoid minimizing his nostalgia or bereavement for his homeland, which may persist for a long time. Problems may arise at any stage of the immigration process. They have an influence on the adaption of the immigrant and his family to the host society.[6]

Intercultural care is a dynamic process based on respect, interaction and mutual exchange between immigrants and health care providers in which the interveners are aware of cultural, linguistic, family, social and behavioural differences (recognition of authority, respect for parents, politeness, honour, dignity, and notions of female modesty) as well as traditional perceptions and interpretations of health care problems and their treatment.

Various social adaptation methods

There are many ways in which the immigrant adapts to our society. This will also depend on his pre-immigration experience, on the conditions of his travel to our country (safe or dangerous), on the reception he received, and of the living conditions that he faced after settling here.[7] The experience may be either positive or *rather* negative, as happens when the immigrant cannot adapt and ends up returning to his homeland or moving to another country.

Intercultural Care

Assumptions:

- **Awareness of the immigration process;**
- **Awareness of certain notions which affect immigrants: health conditions, economic conditions, education level, etc.;**
- **Awareness of the context in which immigrants are received: language and housing problems, discrimination, etc.;**
- **Satisfactory understanding of elements which are specific to each immigrant: culture, values, traditions, religion, superstitions, beliefs regarding health care, etc.;**
- **Awareness of behaviours which should be adopted or avoided;**
- **Strong ability to establish meaningful relations with persons of a different race, colour, culture or religion;**
- **Willingess to help newcomers understand and adapt to our health care system.**

Integration may take the form of **complete assimilation** in which individuals fully adapt to the dominant culture and gradually leave

[6] Canadian Mental Health Association. Équilibre en tête : le processus migratoire. Retrieved from http://www.acsmmontreal.qc.ca/publications/articles/processmigratoire.html .

[7] Berry *et al.* (1986). In Health Canada. Immigration and Health: Perinatal Health. Retrieved on May 22, 2009 from http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/wp-dt/2001-0105-immigration/method-eng.php.

aside their core values and customs. They may even end up losing their language or abstain from transmitting it to their children.

Adaptation may also take the form of **integration**. This is a more conservative and balanced approach in which the immigrant remains true to his culture of origin while adopting the lifestyle of the host society.

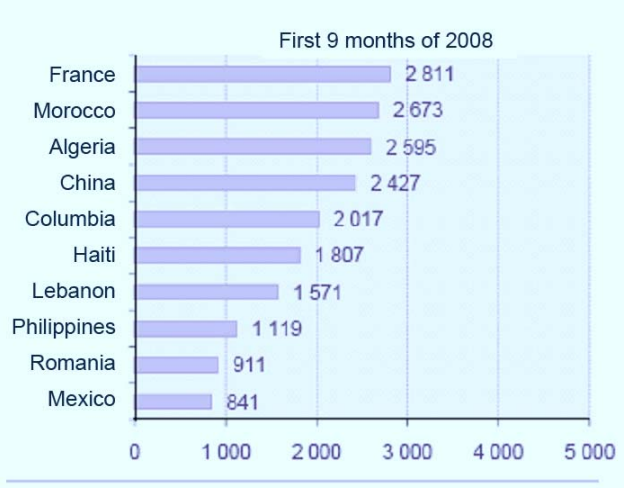
The third option is **separation**. In this case, the immigrant isolates himself from the dominant culture to retain his own identity. This occurs when a certain **ghettoization** takes place and when people of the same cultural origin stay within their group and, avoid contact with immigrants of other cultures and with members of the host society. The fourth adaptation method is the most negative of the lot. It is **marginalization**, which is really a rejection by the host society and the denial of the identity and cultural values of the immigrant. **Marginalization** increases the risk of asocial behaviour and criminal activity.

Ghettoization: the isolation of a cultural group which seeks refuge in its own values and culture, and which avoids contact with the host society.

Developing intercultural competence

Caring for displaced persons and developing intercultural competence requires many skills. First, we must identify and understand who exactly the subjects of nursing interventions are in order to adapt to their distinct reality. Leaving one's homeland involves adaptation problems and uncommon stress which has an impact on health as well as on the cultural, religious and linguistic specificities of the newcomer. This requires that nurses develop specific care methods to respond to their needs.[8]

Acquiring knowledge of incoming populations



We must first closely examine what welcoming to our environment newcomers really entails. We cannot consider them as a monolithic bloc which contrasts with native Quebecers. Immigrants come from diverse backgrounds. They belong to different groups - linguistic, cultural and religious. They have different values and beliefs regarding health care. It is this diversity and heterogeneity which complicates the reception of immigrants. This diversity is also found within similar groups of immigrants.[9] As such, it can be said that beyond certain ethnic similarities, each individual is unique. Nurses do not deal with cultures, but rather with individuals - each diverse and unique at one and the same time. The table below provides a few indicators of success in

[8] Health Canada. Healthy Living: Mental Health – Coping With Stress. Retrieved on May 22, 2009 from http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/life-vie/stress-eng.php.

[9] Statistics Canada. *Recent* Immigrants in Metropolitan Areas: Québec – A Comparative Profile Based on the 2001 Census. Retrieved on May 22, 2009 from http://www.cic.gc.ca/english/resources/research/census2001/quebec/partb.asp.

integrating immigrants. One of the first factors that needs to be considered is immigrant access to services, and in particular to health care.

Indicators of integration

OBJECTIVE INDICATORS	SUBJECTIVE INDICATORS
Access to services: being able to access the same services and to enjoy the same rights as all other citizens.	**Autonomy:** a reference to the notion of *empowerment*.
Language proficiency: ability to communicate and work in French, the official language of Quebec.	**Recognition:** refers to the feeling of being accepted and recognized by the host society.
Access to employment: power to obtain and work in a quality job that reflects and recognizes the level of competence of the worker.	**Sense of belonging:** refers to the feeling of inclusion and of belonging to the host society.
Citizenship: being able to participate as a citizen.	

The first years of adaptation and integration require a tremendous effort and attention to understand the workings of a new culture.[10]

A realistic portrayal of immigrants in Quebec

The environment in which the immigrants evolve needs to be considered realistically in order to understand the population being attended to. To do so, certain factors such as the immigrant's health upon admission, health behaviours, the consultation rate of health care professionals, age, academic level, income and knowledge of French and English must first be examined. All of these factors play a role in the integration of the immigrant to the host society and in conditioning his contacts with health care services. Nurses must also strive to understand the customs, values and concerns of immigrants who must deal with a health care system which plays by a different set of rules. Each year, Quebec welcomes approximately 40,000 immigrants. It is essential that their role and influence on health care delivery and nursing be clearly understood.

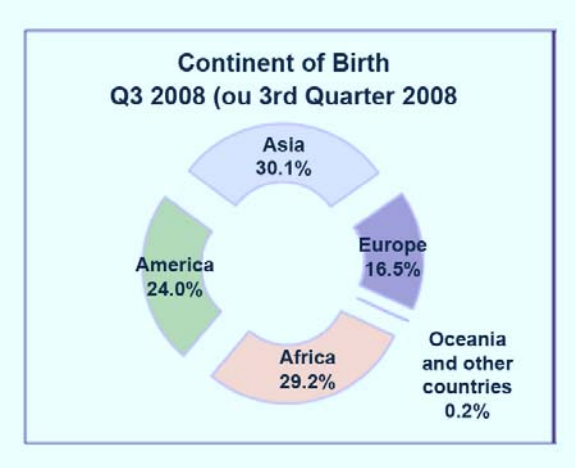
Immigrant origins and integration problems

To understand the reality faced by the immigrant, it must first be acknowledged that newcomers come from diverse backgrounds. Their origins range from emerging nations, which lack basic health care infrastructures, to highly advanced, Western countries.[11] For those from emerging nations, the differences with our values and health care system are so varied and numerous, and for us so obscure, that our lack of understanding sometimes leads

[10] Immigration Lanaudière. Impact du processus migratoire. Retrieved on May 22, 2009 from http://www.immigrationlanaudiere.org/index.jsp?numPage=53&menu=2.
[11] Institut de la statistique du Québec. Caractéristiques de santé des immigrants du Québec : comparaison avec les Canadiens de naissance. Retrieved on May 22, 2009 from http://www.stat.gouv.qc.ca/publications/sante/pdf2008/zoom_sante_juin08.pdf.

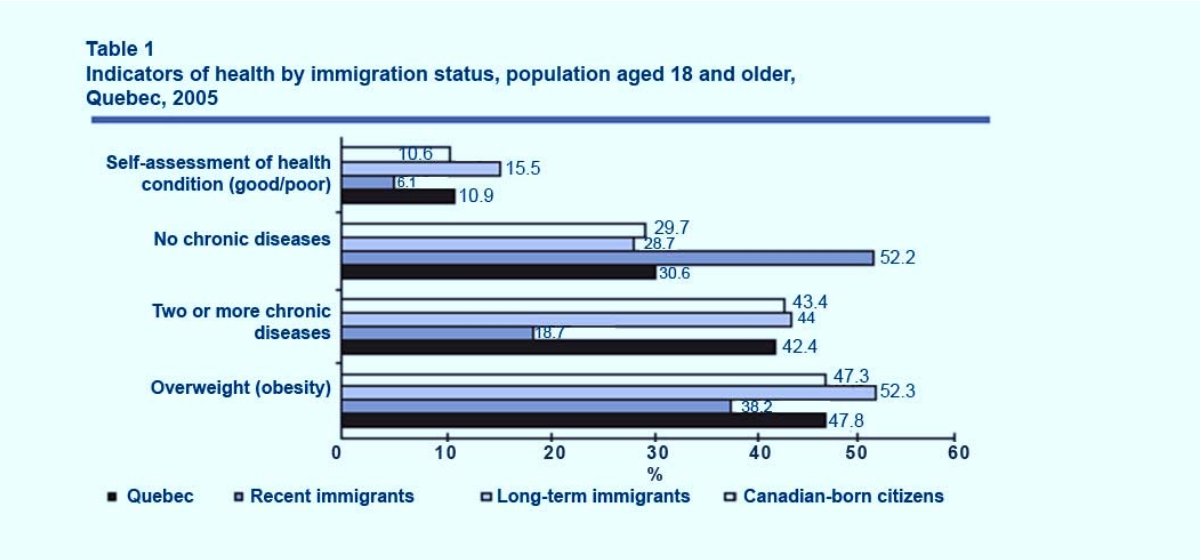
us to fall into the stereotype that immigrants are governed by superstition and outdated knowledge, and that they lack any gratitude for what we are doing to help them.

Convinced of our superior means, we often fail to understand how certain patients can withdraw from the system and show a willingness to return to their traditional practices.



We forget that such care was standard in their homeland. Removing access to their concept of care constitutes not only a source of concern at the medical level, but also a significant source of social withdrawal. Breastfeeding provides a fine example. "In many countries, breasts serve a functional purpose and can be exposed in public. Breastfeeding in public is perfectly natural and does not bother the women of those countries."[12] Furthermore, immigrants from such countries find it hard to grasp how in such a liberal country as ours they cannot breastfeed their babies in a restaurant or in a department store.

In immigrant-attending staff relations, any health topic may be covered, including diseases, contraceptives, birth, breastfeeding, child care, wound care, aging, agony, and death. Such relations may result in a conflict between ancestral knowledge and our forms of intervention. This leads to misunderstanding between the attending care provider and the patient, as well as additional stress and insecurity. For example, an Asian person may deem that what we regard as a physiological complication is in reality an evil intervention, whereas the care providers only



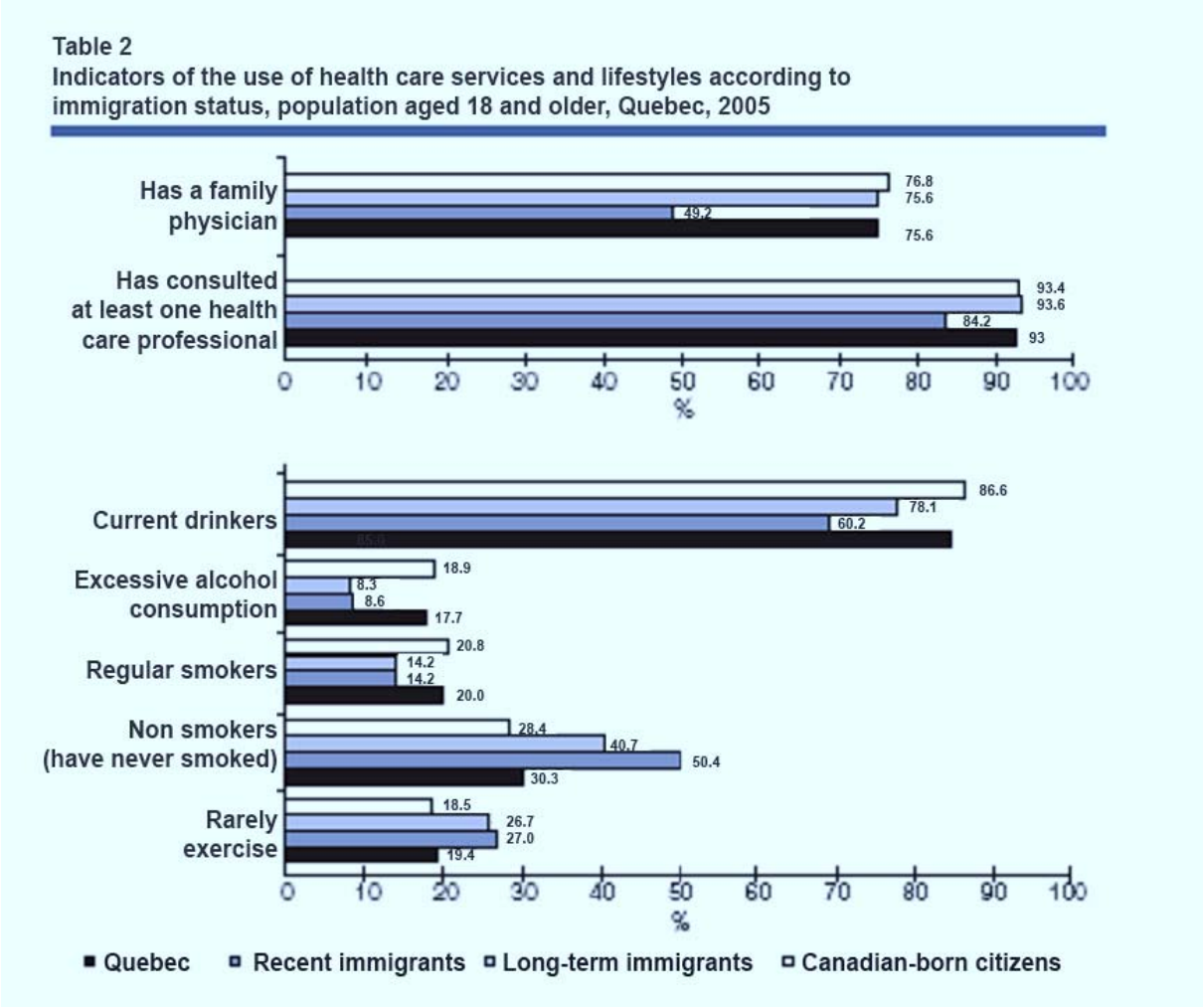
want to provide a rational response. The patient may request herbs or ritual ceremonies to rid himself of his condition. He may become desperate if his requests are ignored. Another example may be an African woman who comes from a nation in which obstetric care is practically unheard of. In spite of receiving effective care, she may complain vocally about the lack of

[12] Attachment Across Cultures. Allaitement, culture et attachement. Retrieved on May 22, 2009 from http://www.attachmentacrosscultures.org/francais/valeurs/bfeed_culture_f.pdf.

human interaction with care providers and support from her extended family, which is absent because of distance and poverty.

The health condition of immigrants and consultations

A common stereotype is that immigrants overwhelm our health care system at the taxpayer's expense. Like any human, they can become sick. That being said, statistical data in Quebec shows that recent immigrants are generally healthier than Canadians (see table 1). [13].[14]



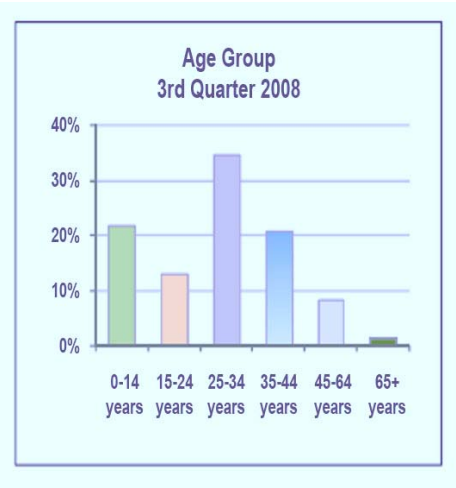
It must also be noted that the statistics provided by the *Institut de la statistique du Québec* indicate that, for recent arrivals at least, their health habits are usually more sound than those of most Quebecers. Even though newcomers are slightly more likely to have a family physician than Quebecers, their consultation rates still remain lower (see table 2).[15]

[13]. Statistiques Canada Enquête sur la santé des collectivités canadiennes. Cycle 3.1.
[14]. Institut de la statistique du Québec. Caractéristiques de santé des immigrants du Québec : comparaison avec les Canadiens de naissance. Zoom santé (June 2008). Retrieved on May 22, 2009 from http://www.stat.gouv.qc.ca/publications/sante/pdf2008/zoom_sante_juin08.pdf
[15] Immigration et communautés culturelles (2008, Q3 and for the first nine months of 2008). Bulletin statistique sur l'immigration permanente au Québec. Retrieved on May 22, 2009 from http://www.micc.gouv.qc.ca/publications/fr/recherches-statistiques/BulletinStatistique-2008trimestre3-ImmigrationQuebec.pdf.

Furthermore, the health behaviours of immigrants are usually less risky than those of Quebecers. They generally smoke less, drink less and are less obese than Quebecers. These indicators on the use of our health care services and on lifestyles are quite revealing. They indicate that we should revise our stereotypes which arose during previous waves of immigration. The results nonetheless fail to illustrate certain problems which may affect certain cultural groups, such as AIDS or diabetes.

Age group

As the table below illustrates, most immigrants are young and aged less than 44. The assumption is that they are in good physical condition but that they will be needing obstetric and child care services. Considering that 61 % are women, that is not farfetched.[16] The older generations are less numerous. Seniors from previous waves of immigration will add to this number. They too will suffer from health problems in the proportions similar to those of native Quebecers.



Level of education

Another significant factor in understanding both our society and our clientele is the level of education of immigrants and their readiness to join the active labour market. This element allows us to get a better grasp of immigrants' understanding and adaptation, of the potential limits of their language proficiency, and of potential obstacles, not only to their social integration, but also to their consulting of health care services, in particular nursing services.

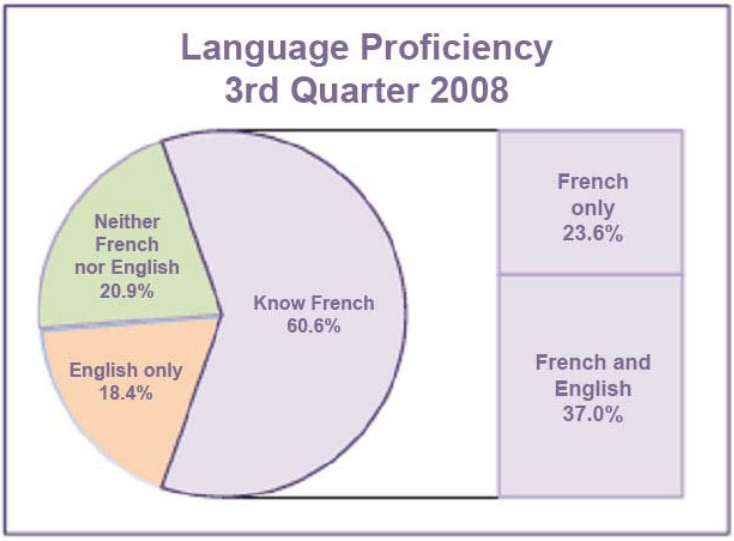
The nurse provides both care and education to patients. It is essential that she grasp how her relations with the immigrant clientele can result in misunderstandings regarding treatment guidelines and also the remaining therapy at home. That being said, immigrants are generally well-educated. In Canada, "in 2007, 37% or 1.2 million immigrants of core working age, those aged 25 to 54, had a university degree, compared with only 22% of the core working-age Canadian-born citizens. The difference was even more pronounced among those who immigrated between 2002 and 2007, with more than half of these immigrants, or 320,000, having a university degree."[17] These numbers can help us fight the widespread stereotype that immigrants are illiterate. Immigrants from previous waves may have less education. Even today, this is often the case with economic immigrants and refugees.

Spoken language

Many immigrants come from either French-speaking or English-speaking countries. Still, 20.9% of all recent immigrants speak neither French nor English.[18] This situation foreshadows

[16] Ibid
[17] Statistics Canada. Study:Canadian Labour Market: Analysis by Region of Highest Postsecondary Education. *The Daily*. Retrieved on May 14, 2009 from http://www.statcan.gc.ca/daily-quotidien/080718/dq080718b-eng.htm.
[18] Immigration et Communautés culturelles (2008, Q3). Bulletin statistique sur l'immigration permanente au Québec. Retrieved on May 22, 2009 from http://www.micc.gouv.qc.ca/publications/fr/recherches-statistiques/BulletinStatistique-2008trimestre3-ImmigrationQuebec.pdf.

integration challenges within Quebec society as well as health care delivery problems. For example, how can these immigrants obtain information about existing health care services and how to access them? Even simple, everyday initiatives can be complicated for them. Just think of the problems involved in finding food in the grocery store, purchasing over-the-counter drugs, finding work or housing, or getting treatment for a child in a language that is foreign to them. How can care providers understand the suffering experienced by these individuals? How can they respond to their needs when they cannot communicate in any language? Finally, how can education on prevention, disease or treatment be provided under such conditions?



The mental health of newcomers

Families which have newly arrived in Quebec often live in conditions which may render them vulnerable at the mental health level. It is important to understand the survival mode in which families evolve. In addition to experiencing adaptation problems and being separated from their natural support network, newcomers must also adapt to an unfamiliar and complex social, political, cultural and linguistic environment. Their overall vulnerability leads them to accept working conditions that are often tantamount to exploitation in order to survive.

They may also face discrimination as well as the disruption and the destruction of their family ties as a result of their migration. These immigrants must also face a new set of challenges on their own, without the economic or moral support of their friends and families. They take on these challenges without relying on health care and social services because they are either unfamiliar with them or find them poorly suited to their reality. Immigrants do not have higher rates of mental health problems than Canadian-born citizens; however, the stressful conditions that they encounter make them vulnerable to discouragement, anxiety and depression.[19]

Cultural incongruity is a difficult experience for immigrants. It can be defined as the confusion experienced by the immigrant who finds it difficult to cope with his own values but who is not necessarily in agreement with those of his host culture.

Some immigrants are more fragile than others. “Visible minority migrants were more likely to be undervalued in the workplace and to earn lower salaries (…) which contributed to the feeling of disillusionment that accompanied resettling in Canada.”[20] Furthermore, “the perception of discrimination is present in all cultural groups that were studied, and it has a negative relation to mental health."[21]

[19] Health Canada. Immigration and Health: Perinatal Health. Retrieved on May 22, 2009 from http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/wp-dt/2001-0105-immigration/method-eng.php.
[20] Ibid
[21] Malewska-Peyre, Hanna. L’identité négative chez les jeunes immigrés. *Santé mentale au Québec*. Retrieved on May 22, 2009 from http://rsmq.cam.org/smq/santementale/article.php3?id_article=170&param=b#e.

One of the greatest challenges occurs among youth "who more often than the locally born population undergo a clash of values. (…) Such conflicts can lead to the destruction of the family and in particular to the rejection of the culture of origin and negative image of the self and of others."[22] They have a hard time identifying themselves and experience what is referred to as cultural incongruity deeply. The most hazardous response is to internalize a disparaging or denigrating image which leads to lack of self-esteem. This in turn may lead to excesses such as marginalization, which has been observed in sensitive neighbourhoods in big cities.

The mental health of women belonging to cultural and ethnic communities

The mental health of women is often put to the test by immigrating to another country. In addition to migratory stress and economic hardship, women experience the tensions associated with pregnancy. They often arrive in the host country at an age to bear children. According to statistics provided by the *Ministère de l'Immigration et des communautés culturelles*, 37% of immigrant women are aged between 25 and 34.[23]

In addition, "certain women must deal with the demands and constraints of providing care to children without the support of the father or their family. Such conditions can trigger symptoms of depression." Immigrant women also face other forms of stress such as lack of knowledge of the local language and medical customs. In particular, they must deal with their pre-immigration past. Many women have suffered severe trauma, which may include torture, rape or the death of loved ones.[24]

Women from cultural and ethnic communities often live in isolation and are left entirely dependent on their families for support. They often suffer from various forms of discrimination (sexual, racial, domestic violence, and so on) and are often left on their own to assume all the family obligations. Such situations create additional stress. Immigrant women may eventually discover that the role of women in their host society differs strikingly

Main Problems Encountered by Women

Lack of independence from their husbands and families.

Problems finding work as a result of:

- **Lack of recognition of education credentials;**
- **Lower wages;**
- **Lack of language proficiency;**
- **Relegation to the services sector.**

Demanding family chores.

Problems associated with pregnancy, childbirth, breastfeeding and maternal care.

Domestic violence and sexual abuse.

Marital and sexual customs of their homeland.

[22] Malewska-Peyre, Hanna. *L'identité négative chez les jeunes immigrés.*

[23] Télé-Québec. Les difficultés des femmes immigrantes et de leurs enfants. *Une Pilule, une petite granule* [Television series epidode no. 89, Feb. 28, 2008]. Retrieved on May 22, 2009 from http://pilule.telequebec.tv/pages/Categorie-de-sujets-dun-emission/dossier-de-la-semaine.aspx?emission=163&date=2008-02-28.

[24] Sword, W., Watt, S. et Krueger, P. (2006). Postpartum health, service needs, and access to care experiences of immigrant and Canadian-born women. JOGNN 35, p. 717-227. Found in La santé mentale des immigrantes enceintes. Retrieved on May 22, 2009 from http://www.ordrepsy.qc.ca/pdf/PsyQc_Dossier_2_Zelkowitz_Mai07.pdf.

from the one in their homeland. It should therefore not be surprising that immigrant women can experience frustration.

The vulnerability that immigrant women experience at the social and family levels leave them exposed to potential sexual abuse. This reflects the perception that other societies may have regarding sexuality and its taboos. Sexuality, in many cultural groups, is only legitimized for marriage and reproduction. Only males are expected to consume for pleasure. The fact that many immigrant women come from societies in which they have little or no rights complicates the job of interveners to raise awareness of health issues, sexual assault and domestic violence.

Immigrant women often lack awareness of Canadian and Quebec standards regarding sexual abuse. They do not know that there are laws which protect them, that certain behaviours fall under the Criminal Code, and that they have recourse. These women are often hesitant to call for outside help. To some of them, sexual violence is an intimate matter that is confined to the couple and the family. As they are unable to communicate in either of the official languages, they remain unaware of available resources. Living in isolation and being excluded from the labour market makes them economically dependent on their husbands. In such circumstances, immigrant women are reluctant to denounce an abusive spouse.

Female migrant youth are also victims without a voice. In order to be accepted by their cultural group or fearing repercussions, they often submit to sexual relations under the threat of violence.[25]

Forced marriages

Many immigrant women were forced to marry their husbands, and their daughters often suffer the same fate. In a few Middle-Eastern, Asian and African communities, marriage is forced upon the spouses, in particular upon women. The parents of both families arrange the marriage. In many cases, the wife has never met her husband. In the name of tradition, the wife is forced by the families to marry her husband under pressure, threat or emotional blackmail. The under-aged daughters of migrants are often victims of this combination of religion, tradition, economic interests, and the desire to please their parents and maintain cultural ties. In Canada, forced marriage is a condemned practice which, in accordance with international conventions, constitutes a violation of individual rights and freedoms.

[25]. MacLeod, Linda and Maria Y. Shin. *Comme un oiseau sans ailes*. Found in Health Canada. Spécialement pour vous – immigrants. Retrieved on May 22, 2009 from http://www.phac-aspc.gc.ca/ncfv-cnivf/violencefamiliale/html/femailes_f.html.

Female genital mutilation (FGM)

Female genital mutiliation (FGM) "involves partial or total removal of the external female genitalia or other deliberate injury to the female genital organs whether for cultural or non- therapeutic reasons."
Source: World Health Organization (WHO). New Study Shows Female Genital Mutilation Exposes Woman and Children to Significant Risks at Childbirth. *The Lancet*.

Some migrants have suffered or are forced to undergo, even here, genital mutilation procedures. Excision is generally performed without anaesthesia on girls prior to puberty. Female genital mutilation (FGM) involves the removal in part or in entirety of the female genitalia. In some cultures, it may even go as far as stitching together the labia in a procedure known as infibulation in order to prevent penetration. This practice is traditional in some communities, but is also often and falsely perceived to be a religious obligation.

FGM is most commonly practiced in Africa, but is also performed in other parts of the world, in particular in certain areas where there are Muslim communities. The *Criminal Code of Canada* specifies that it is illegal to perform FGM in Canada or to transport an under-aged child to another country to undergo genital mutilation.[26] Serious health complications of FGM may arise, especially during childbirth. Women may eventually have to undergo a c-section, suffer from severe haemorrhaging or be forced to prolong their stay in the hospital. Women who have suffered FGM have a 30% greater risk of undergoing a c-section than women who have suffered no mutilation. Furthermore, the risk of post-partum haemorrhaging is 70% greater among mutilated women.[27]

Many reasons have been used to justify FGM, including:

- Ensuring pre-marital chastity;
- Facilitating the marriage of young women;
- Decreasing the risk of nymphomania;
- Reducing female sexuality and preventing masturbation;
- Improving and facilitating cleanliness;
- Increasing fertility;
- Keeping the genital region smooth for aesthetic reasons;
- Removing the labia as obstacles to sexual intercourse;
- Tightening the vagina to increase sexual pleasure for men;
- Being accepted as a member of a social group, tribe, religious order, etc.;
- Fulfilling religious requirements;
- Conferring upon women the right to speak at public gatherings;
- Entering mosques (in some communities);
- Obtaining the right to inherit;
- Avoiding casting shame upon the family.[28]

[26] Department of Justice Canada. Female Genital Mutilation: The Cultural Practice as It Relates to Human Rights. Retrieved on May 22, 2009 from http://www.justice.gc.ca/eng/pi/rs/rep-rap/1995/wd95_15-dt95_15/p3.html.
[27] World Health Organization. New Study Shows Female Genital Mutilation Exposes Woman and Children to Significant Risks at Childbirth. *The Lancet*. Retrieved on May 22, 2009 from http://www.who.int/mediacentre/news/releases/2006/pr30/en/index.html.
[28] Department of Justice Canada. Female Genital Mutilation: The Cultural Practice as It Relates to Human Rights. Retrieved on May 22, 2009 from http://www.justice.gc.ca/eng/pi/rs/rep-rap/1995/wd95_15-dt95_15/p3.html.

According to sociologist Aoua Ly, the arrival of immigrants, even in Canada, has coincided with the emergence of genital mutilations in industrialized nations.[29] According to Amnesty International, some African-born physicians are even practicing excision and infibulations in industrialized nations. Parents who wish to maintain this custom fuel the demand for FGM. The most common culprits are families which send young girls to their homeland under false pretences during the summer break.

"[TRANSLATION] Each year, more than 2 million girls undergo FGM worldwide, and 120 million women of all nationalities are forced to deal with the physical and mental repercussions of these practices. Population mobility has imported FGM into our territory. Every day, childbirths which require disinfibulation (removing the stitches and opening the vaginal orifice) as well as the identification of mutilated girls provide evidence of this practice."[30] By focusing on this reality, by educating women and families, and by alerting medical authorities whenever necessary, the nurse can help to eradicate this terrible practice or, at the very least, to limit its adverse effects.[31]

Conclusion

The data provided above is only a partial image of the situation of immigrants in Quebec. We must be cautious of applying the stereotype that one size fits all because each immigrant has a unique origin and trajectory. That being said, awareness and knowledge of the conditions in which immigrants arrive and are inserted into our society may help us provide them with more effective and adapted care and services. André Gide wrote: "Intelligence is the faculty of adaptation." As the world around us is in constant evolution, we must adapt to the emerging intercultural context and its requirements.

The second and third parts will complete this article. The second part covers notions about cultural specificities which block the adaptation process to our form of care, even when a multicultural approach is enforced. The third section covers communications with immigrants and a few notions on the adapted care method.

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[30] OIIQ (2004, March-April). Forum des femmes africaines. L'excision : un problème encore bien réel. *Le Journal*, Vol. 1(4). Retrieved on May 22, 2009 from http://www.oiiq.org/uploads/periodiques/Journal/vol1no4/ap03.htm.
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