

On Chronic Illness: Immigrant Women in Canada's Work Force – A Feminist Perspective

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Les données d'une étude comparative ethnographique ont été examinées afin de déterminer quels facteurs influencent la gestion de la maladie chez les immigrantes qui ne parlent pas Anglais dans la main-d'oeuvre au Canada. Par rapport aux Canadiennes d'origine européenne, les Chinoises ont un niveau d'études moins élevé et la plupart sont ouvrières. Beaucoup d'entre elles rechignent à révéler leur problème de santé (diabète) à leurs collègues et à leur employeur. Certaines craignent de perdre leur emploi si leur maladie chronique est connue. Les aléas de la vie ont empêché certaines d'entre elles de gérer correctement leur maladie. Dans bien des cas, elles ont eu du mal à accéder aux établissements de soins, elles n'ont pas appris grand chose des spécialistes de la santé et elles avaient peu de ressources leur permettant de comprendre leur état. Ces questions complexes ajoutées au fardeau de vivre avec une maladie chronique n'ont pas toujours été reconnues par les spécialistes de la santé, dont les interactions avec les immigrantes ne sont pas structurées pour révéler le contexte social de la maladie de l'immigrante.

Data from a comparative ethnographic study were examined to define factors that influence the management of illness among Euro-Canadian and first-generation Chinese women in the Canadian labour force. Compared with Euro-Canadians, Chinese women had a lower level of education, and more of them held blue collar jobs. Many of them had reservations about disclosing their chronic health problem (diabetes) to coworkers and employers, some fearing job loss if this information was revealed. Life circumstances prevented some of these individuals from properly managing their illness. In many cases they had difficulty gaining access to health facilities, learned little from health professionals, and had few resources to help them understand their condition. These complex issues that add to the burden of living with a chronic illness are not always recognized by health professionals, whose interactions with immigrant women are not structured to reveal the social context of the patient's illness.

It has invaded me. It has affected my whole life... It destroyed all my views in life, my attitudes, my goals, my aspirations, everything is affected by it. (Anderson, 1987-1989).

Regardless of the cultures from which we come and the social context of our lives, the diagnosis of a chronic illness can cut to the quick of our existence – as this woman tells us – “It destroyed all my views in life.” The news that one has a chronic illness is even more devastating when one is faced with eking out a meagre existence in a labour market where one has marginal status. The daily struggle to make ends meet may well take precedence over attending to

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the demands of a chronic illness. This is the experience of many who immigrate to Canada in search of a better life.

In recent years there has been a marked increase in the numbers of immigrants to Canada coming from different countries. In 1988 and 1989, for example, Hong Kong and India were among the leading source countries of landed immigrants (Canada Employment and Immigration, 1990). While those who migrate usually do so in search of a better life, the process of uprooting from one's home country and reestablishing roots in another often disrupts the social fabric of life and brings hardships. These difficulties are exacerbated when the language and culture of the host country are different from those to which one has been accustomed.

About 50% of immigrants to Canada are women (Canada, Employment and Immigration 1986). Although some are of comfortable means, a significant number of unskilled women are forced into the Canadian labour market out of economic necessity. Our data from a more recent study with randomly selected subjects revealed that about one-third of Chinese women and only three percent of Euro-Canadian women were unskilled (Anderson, 1990-91). Furthermore, some well educated women are unable to obtain jobs at levels similar to what they had in their home countries. Their qualifications are often not recognized in Canada and, for a number of reasons, they have difficulty acquiring the training that would allow them mobility in the labour market. For some women being in the paid work force does not exempt them from housework and childcare responsibilities; they therefore have little time for language and skill training (Anderson & Lynam, 1987). Gannage (1986) observed that the "double day of labour at work and at home made it difficult for immigrant women to obtain the language training that their male counterparts were able to obtain" (p. 196). Many women are therefore trapped in low paying, unskilled jobs, with no hope of mobility in the work force.

McGowan (1982) revealed that nearly one-third of all immigrant women were located in the most poorly paid sectors of the Canadian labour force, compared to only one-fifth of Canadian women and one-sixth of Canadian men. Minimum wage legislation usually did not apply or was not enforced in these jobs, and employer abuses of employees were common (p. 5). The conditions under which some immigrant women in North America live and work are not unlike those described by Brettell and Simon (1986) in the international context: subject to the triple discrimination of sex, birthplace, and class, they occupy the lowest levels in the labour market hierarchy, and have little security with few benefits (p. 10).

The conditions under which immigrant women live and work can have profound effects on their health. Bryan, Dadzie and Scafe (1985) stated that

black women in Britain tolerated the lowest paid jobs with poor working conditions, and dealt with a disproportionately high share of health hazards in the workplace (p. 91). Similarly, Bolaria (1988a) has noted that in Canada the jobs that immigrants are able to get expose them to numerous health hazards. When these workers must also deal with a chronic illness their difficulties are compounded.

Based on ethnographic data obtained from women living with diabetes (Anderson, 1987-1989), we argue that a woman's position in the labour force and the conditions under which she works can be major deterrents to the appropriate management of illness. We also argue that this is not always recognized by health professionals, whose interactions with the women are not structured to inform them of the social context of illness. In addition, the health care system often fails to accommodate the needs of non-English speaking women. It is not our intent to provide a detailed ethnographic report here, nor do we intend to focus upon diabetes as a disease category. Rather, we draw upon ethnographic materials to show that a woman's position in the labour force influences her ongoing management of a chronic illness. Women with diabetes were selected for this study only insofar as this disease requires ongoing management.

We need to go beyond the examination of culture to forward an analytic perspective for making sense of women's situation in the work force. While the discourse on culture gives us a window into understanding the meanings of illness, it does not adequately address issues that shape the experiencing of illness. Neither does an analysis of gender relations by itself provide an adequate explanatory framework for the difficulties immigrant women face. Carby (1982) pointed out that it is not just the institution of patriarchy that needs to be addressed to analyze the situation of black women; they are also subject to the oppression of class and race. She further argued that "racism ensures that black men do not have the same relations to patriarchal/capitalist hierarchies as white men" (p. 212-213). We believe that these comments are also relevant to other women of colour. In order to define the context of immigrant women's experiences feminist theory must be reformulated to address the issues of class and race. We attempt to use such a framework to analyze the experiences of those coming from poorer nations in particular, with their history of colonialism and oppression.

In earlier papers (Anderson, 1991a; Anderson, Blue & Lau, 1991), we explicated the process of life restructuring that occurs with chronic illness. Anderson, et al. (1991) suggested that Euro-Canadian women, fluent in English, were better prepared for jobs in the Canadian labour market. This enabled them to restructure their lives to deal with chronic illness. On the other hand, non-English speaking immigrant women in the lower echelons of

the work force had more difficulty finding jobs that would allow them to attend to their illness. In the current paper we deal explicitly with how the process of migration and the status of "immigrant woman" structure life experiences, and suggest directions for nursing to consider for the competent care of people from all ethno-cultural groups.

Theoretical and methodological perspective of research

The research we present is grounded in a feminist epistemology. According to Campbell & Bunting (1991), *"Epistemology is a theory of knowledge. Epistemology guides methodology, because epistemology concerns the questions of what can be known and who can be knower"* (p. 4). In a feminist approach, women are seen as a legitimate source of knowledge, and as experts on their own lives – women's experiences become the subject of investigation. It is critical and activist in its effort to improve the lives of women and all persons (Campbell & Bunting, 1991, pp. 6-7). In keeping with the perspective derived from Black feminism, we view feminism "as a process of self-conscious struggle that empowers women and men to actualize a humanist vision of community" (Collins, 1990, p. 39). In addition, we draw upon the method of institutional ethnography as explicated by Smith (1987) as a way of doing research. This approach allows us to give voice to the experiences of women, and analyze them within the broader social context. According to Smith:

The idea of an institutional ethnography emphasizes that the inquiry is one of discovering "how things work," "how they are actually put together." The notion of an ethnography lays stress on the project of being faithful to the actualities of social organization and relations. In contrast to research practices beginning with the concepts or theories of sociological discourse, the methods of this feminist sociology begin in an actual situation and explore the actual relations that organize it (pp. 147-148).

The aim of this method is "to explicate the actual social processes and practices organizing people's everyday experience from a standpoint in the everyday world" (Smith, 1987, p. 151). She emphasized that "inquiry starts with the knower... Activities, feelings, experiences, hook her into extended social relations linking her activities to those of other people and in ways beyond her knowing" (Smith, 1992, p. 91). When the experience of illness is viewed from this perspective, it cannot be teased apart from other aspects of a woman's daily life: getting and keeping a job; taking care of small children; cooking the dinner; doing the laundry; providing comfort and support to her partner and other family members; trying to make ends meet; and all the other activities of daily living. Illness becomes yet another thread woven into

the tapestry of her life. It influences, and is influenced by all ongoing social interactions, including those with health care providers.

Within the framework of institutional ethnography we can also extend our inquiry to the wider social relations that organize a woman's experience. For example, it allows us to locate this experience within the context of colonial oppression, and analyze how class and race oppression are perpetuated in a society where many of those who are from the poorer nations of the world are relegated to the lower echelons of the work force with no hope of upward mobility.

In qualitative research, especially research from a feminist perspective, the interviewer is aware that she is very much a part of the process of the social construction of knowledge. That is, although one's assumptions are explicit from the outset, inherent in the process of interviewing is the inter-subjective construction of meaning. Oakley (1981) wrote convincingly of the distinct differences between interviewing from a masculine paradigm and women interviewing women from a feminist paradigm. It became apparent to her that finding out about people through interviewing was best achieved when a non-hierarchical relationship existed between interviewer and interviewee, and when the interviewer was prepared to invest her personal identity in the relationship (p. 41). The interviewee, therefore, is not treated as the objectified other who is there to answer the researcher's questions. Nor are data treated as objective facts about the other, that are independent of the interpretive scheme of the researcher. Rather, there is a process of reciprocity between interviewer and interviewee (Anderson 1991b). Verification of interpretations of the data is an important aspect of this type of research.

Research Questions

The questions we address are as follows: What are the illness experiences of women? How is illness managed on a day-to-day basis? What are the circumstances in women's lives that influence the management of illness?

Method

To elucidate the special circumstances of the lives of immigrant women who have a chronic illness, we focus here on the findings from a recent ethnographic study with Chinese and Euro-Canadian women living with diabetes (Anderson, 1987-1989). We attempt to chart the course of illness over time, and identify the contextual features of everyday life that shape the experience and management of illness.

A letter (available in English and Chinese) explaining this study was given to women from a number of sources, including physician's offices, the Canadian Diabetes Association, and ethnocultural organizations. Some participants also invited their friends to take part. This approach to recruiting women is acceptable in qualitative research, where participants are selected on the basis of their ability to speak to the phenomenon in question. We contacted all interested women to answer their questions, explain the study in more detail, and inform them of their rights as a participant in the study. All participants signed a consent form which was available in Chinese for those who did not speak English or preferred to sign the Chinese version of the consent form.

Study participants included fifteen Cantonese-speaking Chinese women (two also spoke English) who were first generation immigrants to Canada, and 15 English speaking Euro-Canadian women, 13 of whom were born in Canada, and 2 of whom had lived in Canada for more than 12 years.

Although we had intended to match Euro-Canadian and Chinese women on the basis of education and occupation, this was not possible. Thus, the two groups were not similar in these respects. This difference between Chinese and Euro-Canadian populations of women also existed in a sample that we randomly selected from hospital clinics for a more recent study (Anderson, 1990-91). This perhaps speaks to the fact that a disproportionate number of immigrant women are in the lower echelons of the work force (McGowan, 1982). All the Euro-Canadian women, but less than 10% of the Chinese women had a minimum of Grade 11 education. All the Euro-Canadian women who worked outside the home were employed in professional/white collar occupations; only one Chinese woman was likewise employed. Most of the Chinese women in the labour force were in unskilled or skilled blue collar occupations.

The study lasted for two years, with data collection occurring for approximately one year. Two or three in-depth one-hour interviews were conducted with each woman during this time. A set of "trigger questions" pertaining to the areas, as outlined above, (e.g., women's experiences of illness, how illness was managed) were used to initiate the discussions with women. However, in this type of guided conversation questions are generated in the context of the interview, and the interviews are flexible enough to allow people to tell about their experiences from their own perspective.

Interviews with the Chinese women were conducted by a Cantonese-speaking research assistant in the women's homes. Not only did women discuss their beliefs about illness, they also spoke of their experiences in the

workplace and the process of seeking help from health professionals. They described the conditions of their work, and the ups and downs of everyday life that had a bearing on illness management. The interviews were then translated into English, and transcribed verbatim by a typist.

Data collection and analysis proceeded concurrently. As we collected and reviewed the data, women were asked to clarify points that were unclear to us. The data were systematically analyzed to identify conceptual themes. In a subsequent interview, women were able to validate our emergent interpretations to ensure that they were congruent with what they had intended. A further step in the process of analysis was to synthesize the conceptual themes into a coherent account of the participants' experiences of illness.

Illness in social and clinical contexts

The dilemma of managing a chronic illness in the workplace. Health professionals may take it for granted that a woman diagnosed with a chronic illness will reorganize her life to comply with the requirements of treatment. Not all women will find this possible. There are often pragmatic limitations to illness management. We found, for example, that the fear of losing their jobs led some women to keep their diabetes a secret from coworkers and employers: 36% of the Euro-Canadian women, and 67% of the Chinese women who worked outside of the home had reservations about disclosing diabetes in the workplace. For one Chinese woman illness was a private affair that did not warrant discussion with others:

If you have sickness, you don't want to tell everyone in the world about it. You know about it, and you take care of it, and you manage it and live with it. It's a very individual thing. No one can help you with it, so why talk about it?

While some women may have had reservations about discussing their diabetes, none had the fears of the working-class Chinese women. Sixty-seven percent (4/6) of the Chinese women employed in the lower echelons of the work force, feared that if coworkers and employers found out about their diabetes they could be fired from their jobs. Their fears of being fired were grounded in their knowledge that they were without job security.

We draw here upon the voices of Chinese women in the lower echelons of the work force to make visible the collective experiences of women in similar circumstances. When asked if people in the workplace knew about her diabetes, this is what one woman had to say:

Absolutely nobody knows. I would not tell anybody. If I say that I have diabetes, they would not hire me, they would fire me... If you don't plan to work it's okay, or if you are not working, it's okay. If you are working the employer could discriminate against you, and it's very troublesome to have diabetes....

They are very cautious about people with diabetes. They do not trust their work ability. When an employer hires somebody to work, they do not want to hire somebody with illness, especially chronic illness. For example, for diabetes, they would be afraid that you would faint or go into shock suddenly at work. So they would not hire you. Even I am on insulin injection, they would not trust me, so that's why I would not say anything (see also, Anderson, 1990).

While what this woman said could reflect a conception of diabetes as a highly stigmatized disease, it seems that pragmatic considerations about everyday life were foremost in her mind. As this woman tells us, "If you don't plan to work, it's okay." The real concern was that she would be replaced by someone who is seen by the employer as more capable.

The majority of the Euro-Canadian women felt at ease talking with employers and coworkers about the requirements of their illness, and organizing their time schedules to accommodate their special needs, as this woman's account suggests:

I distinctly remember having a discussion with my employer and his associate regarding meetings that were happening at lunch-time, and I told them specifically, I just explained, "I'm diabetic and I am going to have to be able to eat at noon, otherwise I can run into trouble." Basically that's all I said, and they said, "Fine, don't worry about it. We'll take a break for lunch first or we'll..." you know, they were willing to accommodate me and didn't see it as a big obstacle.

A woman's willingness to disclose her illness in the work setting could be related to her ethnicity, but it is more plausibly due to her position in the labour force and sense of job security. Euro-Canadian women who felt vulnerable in the workplace were also hesitant to discuss their illness until they had a sense of how employers and coworkers would respond. Chinese women who felt their jobs were more secure saw the sharing of information about illness as important. This is reflected in one woman's comment:

He [her boss] knows I have diabetes. *This is not a secretive thing. This should be told to the boss so he would know the signs and symptoms.*

One Chinese woman who owned her own restaurant felt no need to keep her illness a secret. Instead, she alerted her employees to her special dietary needs, so that her meals could be prepared accordingly. Feelings of vulnerability, powerlessness and marginality in the labour force were major deterrents to open discussion of one's illness, and this applied whether a woman was Chinese or Euro-Canadian. That more Chinese than Euro-Canadian women felt vulnerable in discussing their chronic illness speaks to the position of immigrant women in the labour market. They could not risk losing their jobs, as few employment options were open to them and they needed the income to survive.

Women who were reluctant to discuss their illness with employers and coworkers had to manage as if they had no special needs. In an effort to keep the information confidential, some were hesitant to monitor their blood sugar on the job or follow dietary regimens. Keeping diabetes a secret posed an outright hazard to one woman who worked in an area where, had she fainted, she would have been injured or killed. Although women feared that if they had a low blood sugar in the workplace no one would know how to help them, they feared the consequences of disclosing their illness even more.

Seeking help: the dilemma for immigrant women. Immigrant women also had difficulties in their encounters with health professionals, and were unable to obtain the services they needed to mitigate the suffering caused by chronic illness. The data suggest that not all women felt able to express their concerns about illness to health professionals, whom they felt controlled the agenda in their interactions. Regardless of which health professional the women saw, they perceived that the medical management of diabetes often took precedence over the concerns of everyday life, even when these were paramount to the management of illness. The following quotation from one Chinese woman informs us that, although she and the physician spoke a common language, she did not feel free to question or express her concerns:

I seldom ask questions. Usually, if I ask or say anything I get scolded by the doctor. Actually, before even I ask the questions I am scolded by the doctor already. I don't have a chance to ask questions.... Every time he treated me like a kid, because he always scolded me, 'now don't eat this, and follow this, and be good'... He always says if you follow my instructions you will not end up like this. He's been saying the same thing over the years, and there is nothing new to say.

This "dialogue" with the physician indicates that, in this instance, the medical discourse was firmly embedded within a paradigm of caregiving where the doctor prescribed and the patient listened.

Not only was there no opportunity for some women to address the circumstances of their lives that influenced how they managed illness, some left the clinical encounter without a clear understanding of the biomedical management of diabetes. The following exchange highlights this:

Woman: With the injections, I often have episodes of feeling cold and shivering.

Interviewer: Did your doctor tell you why you are feeling this?

Woman: No. I told the doctor about this. He just listened but he didn't say anything. He has explanation for it, and I don't understand.... I just don't understand it.

Although some Euro-Canadian women encountered difficulties in their interactions with health professionals, they had access to such resources as libraries and support groups. Immigrant women with limited English skills had fewer resources to access.

A further problem that affected help-seeking patterns for immigrant women is that the delivery of health services was not geared to people who lacked flexible work schedules. Since, during the study period, all hospital clinics in the study area operated during the daytime, women who worked outside the home had to take time off from work to attend the clinic (End-note 2). This meant loss of income for those women who received pay for the hours actually worked. Furthermore, given that women were reluctant to reveal their illness to employers, they were hesitant to request time to seek medical care.

Even when women were able to get to clinics, the lack of trained medical interpreter services was a barrier to receiving care. Non-English speaking immigrants were expected to find their own interpreters. When a family member filled this role, it meant that both the woman and the family member lost pay. Women in the lower echelons of the labour market were most likely to need an interpreter, but could least afford the loss of income for themselves and for their family members. All these circumstances combined to increase the burden of managing a chronic illness.

Making sense of immigrant women's situation

Although, the situation of immigrant women to some extent mirrors that of other women, an analysis of gender relations alone does not adequately explain their situation. A woman's place in the lower echelons of the work force influences how her illness is managed in the workplace. While some Euro-Canadian women found that their work environment was not conducive to illness management, a disproportionate number of immigrant women

spoke to this issue. For the most part, the immigrant woman was in a less privileged position than women from the Canadian mainstream. Without job security, many were forced to conceal their chronic illness. This can have deleterious effects on health. For example, they were reluctant to test their blood sugar at work or to inform coworkers about the signs of low blood sugar.

Health professionals often are not attuned to the conditions under which working class immigrant women live, nor do they seem to recognize how these conditions shape the management of illness. To understand the immigrant woman's experience with chronic illness, we must locate it within the context of her history as a woman (usually a woman of colour), and as a foreigner in a host country whose health care system is geared to the needs of the dominant majority.

Reflections on the category "immigrant woman". The term "immigrant woman" in itself implies a set of social relations that are historically situated. We start from the premise that the category immigrant woman, as Ng (1986, p. 13) suggests, is socially produced through a set of class relations:

Historically, "immigrant women" are the product of capitalist development, which displaces segments of the population from their indigenous livelihood and draws them to centres of new industrial development where they are more and more tied to an economy based on profit making: a monetary economy. "Immigrant women" become a social entity only after the rise of the phenomenon of immigration, which in turn indicates a process whereby different labour supply systems are integrated into the world capitalist economy... and where there is an international division of labour.

Labour market requirements in Western nations determine immigration policies at any given time. For example, some women from ex-colonial societies now provide a pool of cheap labour from which domestic workers are recruited. As more women from the mainstream in Western capitalist nations participate in the upper sectors of the labour market, menial jobs and domestic work within the home are shifted to women from ex-colonial societies. As Bolaria (1988a) noted:

For many workers, coming to Canada is a chance to escape the poverty and unemployment of home and to earn a regular wage, however menial and low-paying the available jobs might be. Their economic needs thus make them susceptible to exploitation. A labour force composed mostly of women and racial minority workers can be hired cheaply (p. 442).

The woman from the dominant capitalist nation stands in a power relation to the woman from the ex-colonial society, an observation that is by no means new. As Carby (1982) has noted, "Both white feminist theory and practice have to recognize that white women stand in a power relation as oppressors of black women. This compromises any feminist theory and practice founded on the notion of simple equality" (p. 214). The relations of power permeate different sectors of the Canadian workplace, where the immigrant woman from a racial minority group, by virtue of the job she is able to obtain, often finds herself in a position subordinate to the Euro-Canadian woman from the mainstream.

This situation highlights the class and power relations between women from different social categories, and points to the need for an analytic perspective that addresses the immigrant woman's experience in relation to her class position in society and history of colonial oppression. In this regard, the struggle of an immigrant woman in the lower echelons of the work force differs significantly from that of women from the mainstream, and her plight is usually neglected in the constructions of feminist theories from a Western standpoint.

The experience of illness by immigrant women, who are probably in the lower echelons of the work force, cannot be subsumed under those of women from the mainstream, in the same way that the analysis of women's experiences, in general, cannot be subsumed under those of men (Anderson, Blue & Lau, 1991; Meininger, 1986). For one thing, the woman in the lower echelons of the work force does not have access to the resources that facilitate chronic illness management (e.g., flexibility in the workplace, and interpreter services in the health care system). This results in a management strategy unique to her life circumstances; a strategy that can be quite different from that used by a woman within the mainstream.

The politics of health care. Health professionals may well detect a difference between immigrant women and middle class Euro-Canadian women in their styles of illness management. The Euro-Canadian woman who has all the resources at her disposal may be better able to adhere to prescribed treatment regimens. She may follow her diet conscientiously and attend carefully to the other requirements of diabetes management. When this happens, she may be seen as a "good patient" who "takes responsibility" for her care. Not only is this woman usually able to reorganize work schedules and access resources to help her, she and the health professionals who provide care to her, may share similar notions about what constitutes good management. For example, both may see, the principles of "self-care management" as desirable. This is not simply because the woman has absorbed the instructions of the health care provider, but because, as Anderson and some of her colleagues have noted

elsewhere (Anderson, Elfert & Lai, 1989), ideologies underlying health care practices reflect the institutionalized order. Patients and practitioners from the same ethnocultural and socioeconomic group have access to similar forms of thought. If a patient manages her own illness by adhering to the principles of self care management, it may have more to do with a societal perspective that values "responsibility for self" than with adherence to a value-free scientific body of knowledge. The immigrant woman who speaks little or no English is usually excluded from the forms of thought within the host culture. The labelling of such a woman as non compliant or failing to take responsibility for self-care has to be understood from her position outside the value system of the dominant culture.

In seeking explanations for a woman's seeming non compliance, health professionals might pay little attention to the mediating circumstances of her life – her work conditions, economic situation and lack of access to health care resources that would compound her distress and confound illness management. This inattentiveness to the complex nexus in which illness is embedded arises from the decontextualization of illness and its management and an individualized view of illness which reduces it to a biomedical phenomenon. The practitioner interacts with the patient to elicit precise information pertaining to the disease, and develops a set of instructions for illness management. Whether or not the patient follows the instructions is seen as an individual matter that rests solely with the patient.

Implications for Nursing

In the twenty-first century the emergence of a feminist scholarship in nursing could allow nurses to provide more compassionate care to people from different ethnocultural groups. This approach would direct us to examine the clients' cultures (and reflect upon our own culture), take the subjective experiences of individuals as the starting point of our analysis, and hold up to scrutiny the social, political and economic processes, including the history of imperialism and oppression, that have shaped – and continue to shape – the lives of many. Ethnicity, per se, may not be the deciding factor in how one experiences and manages an illness, but it cannot escape our attention that a disproportionate number of people from racial minority groups are situated in the lower echelons of the work force. Therefore, it is not their ethnicity but their history of colonialism and oppression that has shaped their subjective experiences. In the current study, women related that the conditions of their work had a profound influence on their health and how they managed a chronic illness. A reflexive feminist perspective demands that we not treat these inequalities as a fact of life, but respond to them in our practice with a new social consciousness, and actively seek ways of improving the human condition.

In other words, knowledge of the life circumstances of immigrant women needs to be utilized on a day-to-day basis in clinical practice. For example, behaviours that could be construed as non-compliance have to be reexamined in light of the conditions of the client's life. The label *non-compliant* infers that the client is at fault, or has chosen not to follow the biomedical model of illness management. For the immigrant woman, however, it may not be her choice but the conditions of life that structure the ways in which she manages her illness.

Analysis and change at the level of interaction with the individual will not be enough to address all pertinent issues related to the care of immigrant women. Issues in the organization like the organization of health care services, like the inappropriate hours when clinics are held, and the lack of adequate interpreter services, must also be analyzed and changed. This means that nurses must be prepared to identify inequalities and work toward influencing social and health policy decisions. The clinical practitioner is well placed to identify inequalities, and the nurse researcher can use findings to influence policy. Together they can bring about change, not necessarily just in the organization of health clinics, but possibly also in the larger societal context. Once we recognize that health and illness are socially produced, it is obvious that the boundaries of nursing should expand to identify and address social and political issues. We should not accept social injustice as a given; instead, we should accept the challenge to work toward social justice for all people.

Summary

To analyze the immigrant woman's situation, and especially the immigrant woman of colour from an ex-colonial society, one must first recognize the context of her experiences. Yet, as Lugones and Spelman (1983) wrote, since the voices of women of colour have been excluded from the feminist discourse, immigrant women have seldom been heard.

The realities of poverty and marginality may be quite foreign to middle class health professionals schooled within the framework of western biomedicine. Therefore, perceptions of health professionals may differ markedly from those of the immigrant woman.

When we recognize the problems that women face as located within the historical, sociopolitical and economic contexts, we will begin to direct attention to the political arena to bring about social justice through legislation that will empower the powerless, and guarantee the rights of the underprivileged and oppressed. It is only then that immigrant women will become partners in the societies in which they toil.

Endnotes

1. We have deliberately avoided the use of the term "developing nations." The terms "developed" and "developing," we believe, reflect a Western notion of what constitutes "development." "Western" is here taken to include European societies under prewar British and postwar American hegemonic leadership." (Ong, 1988: 90). As Ong points out, "neo-colonial preoccupations continue to haunt Western perceptions of ex-colonial societies... [it is suggested that] well known feminist studies on women in ex-colonial societies have not escaped this hegemonic world view" (p. 80).
2. Some evening diabetes clinics are now available in the study area.

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Joan Anderson acknowledges, with thanks, a grant from the British Columbia Health Research Foundation which made this study possible. A Research Scholar Award from Health and Welfare Canada allowed her the time to conduct this study. The views expressed here are not necessarily those of the funding agencies; the authors alone remain responsible for any shortcomings. We wish to thank Annie Lau and Mayeeta Leung for assisting with the ethnographic phase of the study. Our special thanks to the women who gave so generously of their time and allowed us to enter into their lives.