NEWLY ARRIVED NIGERIANS' EXPERIENCES WITH ACCESSING AND RECEIVING HEALTH CARE SERVICES IN CANADA

By

Efe Ehigiato

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Department of Sociology
University of Manitoba
Winnipeg

Abstract

This study explores the experiences of newly arrived Nigerians in the Canadian health care system. This is because Nigerian-born migrants are the largest African migrant group in 2015 (Citizenship and Immigrations Canada, 2016) and it is therefore of importance to gain an understanding of their views on accessing health care services in Canada. This study is guided by the Critical Race Theory and uses semi-structured interviews in data collection. The findings indicate mixed experiences that are both positive and negative in nature. Thus, Nigerian-born residents in Canada do face some barriers in accessing health care services, and their interpretation of such experiences is influenced by their pre-migration expectations, experiences and understanding of health. Some identified barriers include: long wait times, negative attitude of physicians, and discrimination. Some positive enabling factors identified includes: health insurance, availability of resources and infrastructure. Findings from this study offer insights for future research and programming.

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CHAPTER ONE

Introduction

Over the last decade, there has been a steady increase in Canada's immigration such that by 2011, the immigrant population constituted 20.6% of the nation's total population, in comparison to 19.8% in 2006 (Chui, 2013). Recent demographic projections by Statistics Canada estimates that by 2036 the proportion of foreign-born people in Canada could increase to about 24.5% or 30% (Statistics Canada, 2017). The term "immigrants" refers to individuals who migrate/move from a home or source country to a new or host country, in this case, Canada. Foreign-born people can reside in their new host country for varying periods of time depending on their immigration documentation and national immigration laws that govern the relocation and entry of people into a country. In Canada, there are over 30 different programs under which foreign-born people (such as investors, the self-employed, and refugees) can migrate/relocate and reside in the country. There are also 900,000 foreign-born people in Canada on temporary work or student permits.

In Canada, one of the largest non-European ethnic groups are individuals of African origins representing all 54 countries. The African immigrant population cannot be classified as a single heterogeneous group as there exists between them multiple cultural, linguistic, religious, and other differences. Yet much of the research on this group continues to categorize Africans as a singular, cohesive group. As such it is pertinent to examine African immigrants by source country. My research focuses on newly arrived Nigerians in Canada because Nigerian permanent residence permit holders are the largest African immigrant group by source country with 4,133 immigrants in 2015 (Citizenship and Immigration Canada, 2016). Moreover, Nigeria (particularly temporary residence permit holders, and specifically international students) is the

largest African source country group and ranks 10th overall in study permit holders (n=11,966) in 2015 (Citizenship and Immigration Canada, 2015b) and 8th overall in international students (n=6,398) (Citizenship and Immigration Canada, 2015a). Notably, however, we know little about the health and health care experiences of these more marginalized groups, many of whom occupy more liminal spaces in relation to residence status (for instance, they may not be certain they want to immigrate permanently or not, or if they do wish to do so, there may be considerable uncertainty regarding whether or not they can do so).

Nigeria as a country possesses a wealth of natural resources – it is one of the richest countries in natural minerals and resources (Ikeme, 2008) in Africa and is the most populous country in Africa and one of the ten most populous countries in the world (Odia, 2014), ranking 7th most populous with about 182.2 million residents in 2016 (UN, 2015). Furthermore, it is estimated that the Nigerian population accounts for about 2.6% of the world's population. One out of every 40 people in the world identify Nigeria as their home (World Population Review, 2016). From its inception, Nigeria as a country has been ridden with problems often arising from the amalgamation of the northern and southern territories into a single country or political entity by the European colonial power in 1914. As such, the nation's boundary is quite arbitrary, as it was negotiated by the European colonialist without consideration of the possible differences that might exist between the people residing in that particular landmarked geographical area.

As a result, today Nigeria is comprised of over 200 ethnic groups, normally identified by language, (Atanda, 1980; Odia, 2014) which is often fundamental to group culture, and ethnic group identity. The term culture refers to "an integrated pattern of learned beliefs and behaviours that can be shared among groups. It includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs" (Betancourt, Green,

& Carrillo, 2002). Culture can be seen as a way of life of any particular individual or group of people. Thus, due to the differences – ethnic/cultural – among the people occupying the European created geographical boundaries of Nigeria, there have been growing calls for secession of the south eastern region from the country since 1954 - that is, even before gaining independence in 1960 (Ibrahim, 2000).

In relation to migration, the process of relocation to a new country often involves a number of resulting political, economic, social, and health issues for the individuals involved. It has been noted that immigrants' health status and needs have been poorly understood in their host countries, especially in the situation of difficult relocation or immigration experience caused by civil strife/violence in the home country (Pavlish, Noor, & Brandt, 2010). As such, although the superior health status of immigrants at their time of entry (which is largely a product the pre-migration health screening process and socio-economic status) is reflected in the "healthy immigrant thesis" (McDonald & Kennedy, 2004; Pavlish et al., 2010), they face a decline in health by their length of stay in the new countries (mostly after ten years of residence), in part because the health care system is unable to create and tailor services required for their differing needs and also because they tend to adopt the very bad health habits of Canadians as they acculturate (Dean & Wilson, 2010; Guruge, Hunter, Barker, McNally, & Magalhães, 2010; Newbold, 2005; Pavlish et al., 2010). Hence, it is of import to understand immigrants' experiences in interacting with the health care system in the process of gaining access to and receiving health care services as this may play an important role in their health status as well as their immigrant experience more broadly.

Upon relocation to another country, immigrants can face some settlement – "adjustment and integration" – difficulties related to language, education, and lack of knowledge about

existing services, which affect their acculturation to their new homeland (Teboh, 2015). Immigrant settlement issues are an important focus within the body of literature on social inclusion, which seeks the "dismantling of barriers" that foster the exclusion of immigrants in their new society or host country (Omidvar, Richmond, & Foundation, 2003). My research focuses on the health care aspect, and extends this inquiry to consider the experiences of temporary residents: specifically, newly arrived Nigerians' experiences accessing and receiving health care services in Canada. This is a settlement concern and a health concern, since Nigerians' health and well-being can be influenced by their ability to access health care services when needed.

As well as having benefits for well-being, access to these services represents an important form of social inclusion. Social inclusion refers to "the basic notions of belonging, acceptance and recognition. For immigrants and refugees, social inclusion is represented by the realisation of full and equal participation in the economic, social, cultural and political dimensions of life in their new country" (Omidvar et al., 2003). Existing research has found that well-being in foreign-born residents is associated with health satisfaction, longevity and physical health, including recovery from illnesses such as stroke, coronary artery diseases and so on (Diener & Chan, 2011; Tsaousis, Nikolaou, Serdaris, & Judge, 2007). The experience of discrimination, structural barriers and exclusionist policies (barriers to health care services, lack of recognition of foreign credential and so on) by foreign-born residents in the resettlement process in their new host country can have negative influences on their overall well-being, which can contribute to a decline in their overall health status (Kuile, Rousseau, Munoz, Nadeau, & Ouimet, 2007; Lauderdale, Wen, Jacobs, & Kandula, 2006). Again, however, we know little about the specific challenges faced by those with more uncertain residency status, like international students, but

for temporary workers – especially agricultural workers, there exists a body of research on their experiences with accessing health care services in Canada.

Research on immigrants' health status in Canada has been largely quantitative and largely focused on cross-sectional rather than longitudinal analyses of survey data (Acevedo-Garcia, Bates, Osypuk, & McArdle, 2010; Dunn & Dyck, 2000; Frisbie, Cho, & Hummer, 2001; Lauderdale & Rathouz, 2000; McDonald & Kennedy, 2004; Ng, 2011; Wang, 2014). There has been less attention, however, to issues related to health care access and utilisation by immigrants (relevant literature is reviewed later in this thesis) (Asanin & Wilson, 2008; Dastjerdi, Olson, & Ogilvie, 2012; Gagnon, 2002; Guruge et al., 2010). Canadian health care consists of a combination public-private system where health services are delivered through private and not-for-profit entities – hospitals and private clinics (i.e. walk-in clinics) that are primarily financed by the government. The healthcare system is regulated by the *Canadian Health Act* and the federal government transfers money to provincial governments for the provision of subsidised health insurance plan and services (Bridge, 2007). The provinces, in turn, determine how these funds and in what sectors, they are spent. For example, Manitoba is the only province in Canada that funds chiropractic services (until spring of 2017). Universal health care coverage is provided by publicly funded health insurance which is granted to every individual as a right of citizenship and residence in Canada – except coverage for vision/ eyeglasses, outpatient medications, dental care, and cosmetic surgery (Olsen, 1994, 2007).

Immigrants are often at a disadvantage in relation to provincial subsidised health insurance coverage as they are often unentitled to coverage for the first three months of their residence in Canada (Asanin & Wilson, 2008). This three-month lack of health insurance can negatively affect their health status and is one of the identified barriers to accessing health care services in Canada for this initial duration. Beyond health insurance, however, other factors may

also affect immigrants' access to and utilisation of health care services, including the extent to which these services align with their beliefs or worldviews on health or health care.

1.1 Research Aims and Objectives

This research explores the research question: "How do newly arrived Nigerian international students interpret their experiences of accessing/receiving health care services in Canada?" Critical Race Theory provides a lens through which the access barriers and experiences of this group of immigrants can be analysed by taking into account overt and covert discrimination on the basis of race or ethnicity in health care access and receipt while also seeking means of reducing such barriers to quality health access and outcomes. Using this theory much as Kereyo and Flomo (2012) have done in their research on removing barriers to health care services for new immigrants, this research proposes the creation of more inclusive health care policies that acknowledges the diversity of the nation's population which as a result would leave room for alternative service delivery system that does not exclude immigrants from receiving the required health care services as quickly as possible.

This research also illuminates social implications of resettlement problems that can result from difficulties arising due to hindered access to health care services among new immigrants. This research is important because immigration is increasing in Canada and settlement issues they might face, including issues in accessing and receiving required health care services, can have important implications for their future acculturation, sense of identity, and productivity. For temporary visitors, access to health care services might even shape their decision on whether or not to remain in the new host country. Furthermore, hindered access to health care can negatively affect an individual's health status as well as their ability to successfully integrate into the Canadian society (indirectly impacting their families and friends); over time, it can affect the

overall health status of immigrant populations. As this research question focuses on the experiences of particular individuals, it can ascertain contextualized information about the health care seeking behaviour of this particular group of immigrants including how they navigate access to health care in Canada (compared to in Nigeria) and as a result it would serve as a backdrop for advocating for and creating more inclusive health care programs which would improve their health care experience.

This research provides in-depth knowledge on the experiences of a particular group of African immigrants in accessing health care services in Canada, and the findings of this research contribute to body of knowledge and research on how African immigrants and temporary residents access health care services in Canada. Research that is specific to source countries in Africa currently tends to be limited. Overall this research is of importance as immigrants' health status has become an important area of analysis/study in academia; immigration issues have gained voice in recent times due to the rise in immigration rates into Canada.

As such, this research contributes to the generation of knowledge in the area of non-Canadians' experiences with Canadian health care, as it focuses on the experience of newly arrived Nigerians. This work also contributes to the body of research on African immigrants by focusing on a distinct group by their specific source country – Nigeria – because most avaliable research tends to homogenously define African immigrants without differentiation by source country. Moreover, existing literature has focused more on Asian immigrants (Asanin & Wilson, 2008; Wang, 2014) or on immigrants' health status, using quantitative methods of analysis which do not provide rich understanding of the contexts of experiences (Fuller-Thomson, Noack, & George, 2011; Newbold, 2005). Additionally, findings from this research can have program implications, helping to minimise the barriers to accessing health care and improving health care

service delivery in relation to providing culturally competent health care services to newly-arrived Nigerians (including international students).

Further, this research could serve as the backdrop for further studies which could further explore whether or not Nigerian born residents require special services – culturally competent health care – or a more inclusive approach to health which is more holistic than that available within the current fragmented system. Indeed, greater health care satisfaction among the immigrant population could have a positive impact on their sense of belonging to Canada, which is important in the face of increasing immigration rates to this country. In summary, this research is intended to increase the understanding of access to health care by newly arrived Nigerians (immigrants and temporary residents) by taking note of the possible barriers they may face, and as a result, this study draws attention to the specific health care needs of these groups.

My choice of this research area is influenced by my position as a Nigerian immigrant in Canada who has had negative experiences accessing the health care system here. Specifically, my experience was characterised by disappointment, failure and unmet expectations as the service was delayed and rushed. This caused me to consider how Nigerian immigrants gain access to health care in Canada because of its different structure and approach (i.e., fragmented nature versus prior holistic health) and service provision (i.e., rushed, 10 minutes per consultation).

This introductory section is followed by a review of the theoretical focus and relevant literature on immigrant health status, barriers to accessing health care services and so on (Chapter 2). Next, a methodology chapter details how this research was conducted, including how participants were recruited, method of data collection, and the methods used in analyzing the data (e.g., coding, constant comparison, interpretive method, ethical considerations). This is followed

by two findings chapters outlining participants' understanding of health, their experiences accessing health care in Nigeria and Canada, and the complexities involved in their evaluations of health care services. The last section (Chapter 6) is the discussion, conclusion and recommendations derived from the findings of this study.

CHAPTER TWO

Theoretical Framework and Literature Review

2.1 Critical Race Theory and Anti-Racism Framework

This chapter explores the theoretical framework which informs this research and the chapter begins by examining the theoretical perspective of the research, which is Critical Race Theory by giving a brief background on the theory and its utilisation in health research. This is followed by a background of the study population, and then analysis of relevant literature related to immigrant settlement difficulties. The final section analysis the Canadian health care system while also reviewing access and barriers to accessing health care services in Canada and other developed countries with a focus on Canadians, vulnerable population and most importantly immigrants.

Research on barriers to accessing quality health care services by immigrants in their host countries has used theories/approaches like the behavioural model, cultural explanation models, ecological framework, vulnerability model and so on. For the purpose of this research, the main theoretical tradition which informs this research and the later analysis is Critical Race Theory. Critical Race Theory was used by Kereyo and Flomo (2012) in their study on barrier-free service delivery as an approach to settlement services for newcomers. The Critical Race approach began as a movement of academics and scholars who were interested in studying the relationship and intersection between race, racism and power (Delgado & Stefancic, 2012). The foundation of Critical Race Theory lies in the critique of the Critical Legal Studies movement which alienated people of colour and their experiences in its discourse. Thus the critical race movement was

formally formed by Black and other racialized scholars at the tenth National Critical Legal Studies Conference in 1986 (Alyward, 1999, p. 27).

In its conceptualization, Critical Race Theory begins with the idea that racism appears normal to people in North American society as it has been intertwined in the foundation of this society, such that they see it as normal and natural (Ladson-Billings, 1998). In its process, Critical Race Theory encourages the utilisation and recognition of experiential knowledge of the marginalised people and communities under study as it gives them a voice to tell their stories about their experience (Ogbuagu & Baffoe, 2015). This experiential knowledge is considered important as the experience of oppression – racism, sexism – forms the basis of the standpoint development of Critical Race Theory analysis (Ladson-Billings, 1998). In relation to the Canadian Society, Critical Race Theory also explains the existence of racism in the Canadian society, especially in relation why it is maintained and rarely questioned, which is due to the nation's image of racial and cultural tolerance despite the reverse being the case (Alyward, 1999). Furthermore, Critical Race Theory explores alternatives to the discriminatory laws - and in this case systems of service delivery which includes affirmative action policies (in the US) and employment equality (in Canada) that would aid reducing the disadvantages faced by racialized people in the society (Alyward, 1999, p. 34). One major weakness of Critical Race Theory lies in its theoretical nature – "shaking the existing epistemological and ontological orders" (Subotnik, 1998, p. 690). As a result it fails to offer practical solutions to issues it examines or outlines, as racism issues or experiences are difficult to prove or present objectively; the approach focuses on emotions and feelings of individuals and in some cases the researcher (Subotnik, 1998). Despite this weakness, Critical Race Theory is of importance as it situates racial issues of a multicultural society like Canada in a larger context or body of research/analysis that goes beyond the regular service approach as there is ample evidence of the existence of racism in Canada such as the

existence of slavery in Canada in 1709, or the exclusion of minority racial groups from legal profession or mainstream institutions (Alyward, 1999, pp. 40-44). As such, Critical Race Theory provides an appropriate perspective for promoting multi-culturally appropriate settlement services which consider the diverse cultural approaches and interpretations of both newcomers and the mainstream society in the creation of services (Kereyo & Flomo, 2012).

This theory advocates for cultural and social inclusion in service provision and creation, which ensure equal and opportunities and eliminate barriers in access to services (health care services) for racial minority groups or immigrant groups in the society. In relation to this study, Critical Race Theory was used in informing my understanding of the problems that exist in the health care delivery system for racial minority immigrants, specifically for newly arrived Nigerians in Canada. This research also focuses on the disjuncture between immigrants' understanding of health and health care and the more dominant conceptualizations evident within mainstream Canadian society. The key terms and concepts in this research are; health, access, barriers, cultural competence, settlement difficulties (these are defined below drawing on existing literature).

2.2 The Nigerian Society

In other to understand the health experience of this particular group of immigrants, it is important to understand and acknowledge their background and facts about the source country. Nigeria as a country is facing a series of problems - ranging from economic, to political, to religious, to ethnic, educational and lastly to health care (which is the focus of this research). For instance, in Nigeria, the rural regions and lower class city neighbourhoods often lack basic infrastructure such as good roads, a clean water supply, and access to high standard health care services, while the country has a whole has major issues with an instable electricity supply.

Further, in relation to religious issues and conflicts, due to the religious pluralist nature of the country – Christianity, Islam, and African Traditional Religion – there has been a number of religious conflicts mainly between Christians and Muslims (Sindima, 1990). Since its' political independence, Nigeria has faced a great number of conflicts with ethnoreligious underpinnings – from the Maitatsine Muslim-Christian conflict in 1980 to the recent Boko Haram insurgency in 2009 (Adesoji, 2010; Salawu, 2010) – which to date has claimed many lives and has caused people to migrate under refugee status to developed countries. Nigerians have often been described as "very religious" people (Onibere & Adogbo, 2010), as religious and cultural traditions and beliefs significantly shape their lives, interactions, and choices (Odia, 2014). Even political leaders have been characterised as strongly religious, as evidenced by public comments from such leaders, such as: "God being on our side", "by God's help", "God willing", and so on (Onibere & Adogbo, 2010).

Since the 1970s economic, social and political factors have spurred emigration from Nigeria to other more developed countries (Adepoju, 2006) – mostly to UK and US. This migration was highly skilled in nature as migrants relocated to developed countries to pursue better education or work (De Haas, 2006). The restructuring of UK's Health Service created an opportunity for the migration of some poorly paid health care professionals in Nigeria to the UK for better job satisfaction and remuneration. Also, education is a major drive for emigration in Nigeria as people migrate with their family or alone in quest for better educational attainment in the face of the dismal state of the Nigerian education system (De Haas, 2006) which is often characterized by poor infrastructure, frequent labour disruptions in public tertiary institutions, high cost, and sometimes substandard private tertiary education. Since the 1980s, there has been an increased diversification in migration destination countries like Germany, France, Netherlands, and Belgium, as well as Gulf states, by highly skilled Nigerian migrants – students,

professionals, entrepreneurs, and so on. Furthermore, labour migration has become more feminised with the growing migration of female nurses and doctors to countries such as Saudi Arabia (De Haas, 2006).

The growing rate of emigration of skilled, highly educated labour from Nigeria to developed countries such as Canada has contributed to its "brain drain" ("the international transfer of resources in the form of human capital" as per (Beine, Docquier, & Rapoport, 2008, p 3); this is believed to have a negative impact on a nation's income level and eventual development. Hai De Haas (2006) estimates that since the turn of the 21st century, over 300,000 first generation Nigerian migrants (excluding undocumented/illegal migrants, second or third generation migrants) currently live abroad in non-African countries (e.g., UK, US, Canada, Germany, Italy, Ireland, Netherlands etc), and there is a tendency for temporary immigrants to seek permanent residency in their new host country. There is also a growing rate of migration among Nigeria's trained health care professionals (Adepoju, 2006). This has a negative consequence on Nigeria's health sector as it is unable to expand due to the shortage in available physicians who are the backbone of the health sector. This shortage has left Nigeria in the situation of having a ratio 18.5 physicians to 100,000 patients (Hagopian et al., 2005).

2.3 Nigerian Health Care System and Cultural Beliefs Shaping Health Behaviour

Health care in Nigeria is generally found in three forms - Western or orthodox medicine, African traditional medicine and spiritual healing (Isola, 2013). The existence of differing health care forms in a society has been termed "medical pluralism" (Segall & Fries, 2011, p. 356) which essentially refers to the "co-existence of differing medical traditions, grounded in different cultural principles or based on different worldviews" (Segall & Fries, 2011, p. 356). Western or orthodox medicine, like the name implies, has its origin in the western world as it was introduced

to the Nigerian society during the colonial era as it initially catered to European colonists and later extended to the Nigerian public (Alubo, 2001). African traditional medicine existed and was practiced in Nigeria decades before colonialism and it focuses on the cure, prevention and promotion of physical and spiritual wellbeing through the utilization of medicinal plants and herbs (Isola, 2013, p. 320). Spiritual healing refers to attaining good health or cure from illness via divine or supernatural means through prayers, churches and so on (Alubo, 2001; Uyanga, 1979).

Health care in Nigeria is primarily based upon and provided through the orthodox health care delivery system, supplemented to some extent by African traditional medicine which co-exists side by side and which is often used to complement orthodox services by Nigerian health care consumers (Isola, 2013; Daniel A. Offiong, 1999). Nigerian health care is both public and privately owned and run, and is financed through a combination of tax revenues, private out-of-pocket payment for services, donor funding and health insurance (Olakunde, 2012). As confirmed by Abimbola et al. (2015), about 74% of health expenditures are covered privately by households, primarily through out-of-pocket payments by those who become ill. Furthermore, the existing National Health Insurance Scheme (NHIS) only covers about 4% of federal government workers.

Essentially, the Nigerian healthcare system operates on a "pay-as-you-go" or "cash and carry" basis which is a fee for service system involving both private and public health care institutions (Mackintosh & Tibandebage, 2004). It involves a series of user fees (Olakunde, 2012) and transaction costs (Abimbola et al., 2015) which may include a combination of consultation fees, entrance fees, medical material costs, drug costs, and so on (Olakunde, 2012). This can negatively affect health status and health care access of low-income households as health care needs were deferred and only sought for critical illnesses (Mackintosh &

Tibandebage, 2004). Thus, the Nigerian health care system is a deeply flawed system that often ridden with inequity as it greatly depended on one's own ability to pay both the formal and informal cost of health care services.

Problems within the health care system, may in part contribute to the decision to migrate to another country or a developed country; although it remains to be confirmed empirically, it is possible that some individuals may seek access to better health care facilities and services elsewhere. Other factors more directly linked in empirical research to immigration decisions (i.e., "push factors") are primarily economic in nature may include: high unemployment rates, underemployment or low job prospects, and also political corruption/ instability (Adepoju, 1998; Spaan & Van Moppes, 2006). "Pull" factors that influences individuals' drive for (at least temporary) international migration from Nigeria may include a desire for foreign educational credentials (De Haas, 2006), which convey an advantage in the Nigerian labour market. Further, as Adeyanju and Oriola (2012) note, there is a high status ascribed to people who have lived abroad for a period by members of their local communities; such impressions are influenced by the colonial narrative of the European lifestyle that has become an accepted notion. Thus, such people are often viewed more positively, as it is expected that their sojourn in the Western world has had some transformative influence on their lifestyle, accent, skin colour, knowledge, and so on (Adeyanju & Oriola, 2012). As such, it can be argued that immigrants, even temporary ones, often bring with them a series of pre-migration expectations; whether or not these expectations are fulfilled or remain unmet can be tied to issues resulting from their immigration experience and status. As a result, immigrants can experience a range of settlement difficulties that may affect their impressions of the host country.

2.4 Settlement Difficulties

New immigrants' settlement experiences differ by source country, pre-migration experiences, culture, language ability, income, social class and so on. Furthermore, their initial settlement experiences can play a key role in influencing their long-term acculturation, integration and identity formation in the host country (Danso, 2001, p.4). Settlement difficulties which immigrants face may result from barriers to accessing social support/services, lack of social networks, disrupted or de-valued social relations in the host country and so on (Stewart et al., 2008) and as such, quality settlement services are required to reduce and hopefully prevent settlement problems. This is of importance as settlement problems are often intensified in the face of negative migratory experiences – relocation caused by civil strife, war and persecution in the source country; for instance, the Boko Haram insurgence and terror attacks led to the loss of lives, property and displacement of over 900,000 individuals in the northern region in Nigeria (Okoro, 2014; Omole, Welye, & Abimbola, 2015; Sergie & Johnson, 2014).

In these situations, immigrants are often unable to bring with them the financial resources and documentation needed for an easier integration process and as such, may experience significant barriers in gaining access to education, employment, social services, and health care (Stewart et al., 2008). Thus, in such situations, successful settlement and acculturation speed are largely influenced by existing services made available in their new host country (Nash, Wong, & Trlin, 2006) as well as the reception of the host country (Danso, 2001, p.8). Acculturation is important in immigrant settlement and involves the adoption of beliefs or behaviour as well as the resulting changes in cultural patterns due to continuous direct contact with different cultural groups in a society (Berry, 2005; Lopez-Class, Castro, & Ramirez, 2011; Sam & Berry, 2010; Teske & Nelson, 1974).

The existence of settlement issues that hinder immigrants' successful integration into the new host country can also be linked to the existence of exclusionist policies or systemic discrimination which can subtly influence their access to and use of vital services (Malmusi, 2014; Meuleman & Reeskens, 2008). For instance, in Canada, African and other non-white skinned immigrants by virtue of their race and skin colour are visible minorities, and as a disadvantaged group, they can experience systemic forms of discrimination. The term "visible minority" refers to "persons other than aboriginal peoples, who are non-Caucasian in race or non-white in colour" (*Employment Equity Act*, S.C. 1995, c. 44). Visible minority persons make up 78 percent of immigrants arriving between 2006 and 2011, up from 12.4 percent in years before 1971 (Chui, 2013). Furthermore, the projection for the visible minority or non-European immigrant population group estimates the population will constitute about 34.7% to 39.9% of the total Canadian population by 2036 (Statistics Canada, 2017).

Using Critical Race Theory, Ogbuagu and Baffoe (2015) find that the experiences of most visible minorities in Canada are characterised by feelings of "alienation, racism and sense of not belonging" (p. 102). Study participants also reported that they experienced inequities in treatment with respect to access to certain resources and privileges, such as employment opportunities, good housing and health care services (Ogbuagu & Baffoe, 2015). Further, studies also find that the term "visible minority" serves as a mask or cover for employment-based inequalities, since differences between racial groups – African, Asian and so on – are ignored or left relatively unexplored; this is importance, since different ethnic/racial groups have differing levels of access to employment opportunities. For instance, African visible minority persons experience higher unemployment rates than their Asian counterparts (Owusu-Bempah & Wortley, 2014). For instance, participants in this same study opined that the "visible minority" label was often used by some employers as a screening tactic; in other words, that people who

self-identify as a visible minority are often not hired, even though such employers profess equal opportunity (Ogbuagu & Baffoe, 2015, p. 102). Another study reveals similar findings; participants believed they were being treated as outsiders when seeking employment due to their race, name, foreign credentials, and work experience; they believed that people with non-white canadian family names never get called back when resumes are sent out (Huot, Dodson, & Rudman, 2014).

In relation to health care services, research also finds that visible minority individuals often experience discourteous care and stereotypical attitudes, and this serves as a barrier to receiving quality services; 73 percent of respondents (220 participants) admitted to being on the receiving end of poor or substandard services due to their visible minority status (Ogbuagu & Baffoe, 2015). Thus, this indicates a need for inclusiveness in relation to immigrants in Canada through the creation of socially inclusive policies and practices. Here, the term social inclusion characterizes the ways in which "belonging, acceptance and recognition" are achieved through "the realisation of full and equal participation in the economic, social, cultural and political dimensions of life in their new country" (Omidvar et al., 2003). In an inclusive Canadian society, everyone's skills would be fully utilised; for instance, unemployment and underemployment of immigrants would be greatly reduced. This include the recognition of foreign credentials and experience which would reduce the deskilling, underemployment and "brain abuse" (Bauder, 2003) of immigrants and as a result improve economic outcomes while also contributing to or determining better health outcomes (McGibbon, Etowa, & McPherson, 2008; Spitzer, 2012). Further, Martin Pappillon (2002) also notes that health care, too, helps create the necessary conditions for successful long-term integration and settlement of immigrants, enhancing their sense of belonging. Access to suitable health care also helps ensure that their health does not decline due to unmet health care needs. This is important, since various disadvantages that

immigrants face can includes stress, underemployment, discrimination, and these may negatively affect their health (Simich, Beiser, Stewart, & Mwakarimba, 2005).

As the site of analysis in this research is the Canadian health care system, there is a need to understand its basic system and processes; as such, the next section provides a basic overview of the Canadian health care system and how it functions.

2.5 The Canadian Health Care System

The Canadian health care system in its basic form is a public-private system whereby medically necessary health care services are publicly financed by the federal and provincial governments under the provision of the *Canadian Health Act* of 1984, yet provided privately either through not-for-profit entities – such as hospitals – or in some cases, through private walk-in clinics (Bridge, 2007). The *Canadian Health Act* is a funding law which loosely governs the terms of transfer of funds from the federal to provincial governments for the provision of subsidised health insurance to its population (Bridge, 2007). This Act is intended to protect basic principles of universality, accessibility, comprehensiveness, portability and public administration (Hutchison, Levesque, Strumpf, & Coyle, 2011; Lewis, Donaldson, Mitton, & Currie, 2001). Under this Act health insurance is meant to: cover the whole population using the same terms and conditions, fund medically necessary care, be coordinated by a public non-profit authority, and prohibit extra-billing or user charges for patients (Bridge, 2007; Hutchison et al., 2011; Lewis et al., 2001). Thus, the Canadian health care system provides universal, publicly funded health care insurance coverage to its population, with some exceptions for vision care, outpatient medication/prescription medication, dental care, and cosmetic surgery (Olsen, 1994, 2007). Other services such as home care support are not protected under the Canada Health Act, but are

often insured in some form by all provinces and territories (often with some means-tested service charges).

Despite the expected universality of the Canadian health care system and its insurance coverage, immigrants face a number of barriers or are often at a disadvantage. For instance, provinces including Manitoba, B.C., New Brunswick, Ontario, Quebec and Saskatchewan have rules excluding new immigrants from receiving provincial health insurance coverage for a few months upon arrival to the province (Asanin & Wilson, 2008; Gagnon, 2002; Kuile et al., 2007). Furthermore, the Canadian health care system generally has disadvantaged immigrant and low-income populations as a result of health care reforms that exclude more types of care from coverage under the provision of the *Canadian Health Act* such as prescription medication, physiotherapy, chiropractic services, dental, and optical care (Birch & Gafni, 2005). Immigrants' often face double jeopardy as they are often unaware of the services provided or covered under the Universal Health Insurance scheme and they may be unable to afford the cost of such uninsured services. This places these groups at a disadvantage especially in the face of culturally insensitive services, which ultimately creates distrust in the health care system (Newbold, 2005).

Furthermore, temporary migrants, whose residence in Canada is shrouded with uncertainty (such as temporary workers, especially in agricultural activities), are in a more disadvantaged position in relation to accessing health care services in Canada. Studies on temporary workers and their access to health care services finds that they experience hindered access to health care services, which is often linked to their exploitation by their employer and lack of knowledge about the health care system (Hennebry, McLaughlin, & Preibisch, 2016; Preibisch & Hennebry, 2011). In the case of international students in Canada, one study finds that they also experience similar barriers as immigrants in relation to the three month wait time for provincial health insurance, during which students must have private insurance – and thus

had to first pay out-of-pocket for any medical charge, of which a portion will be reimbursed by the insurance company at a later time (Burgess, McKenzie, & Fehr, 2016). This initial out-of-pocket cost became a barrier for students in that study as they sometimes could not afford this cost. Other barriers to accessing health care services were related to lack of knowledge about the health care system and how to access it (Burgess et al., 2016).

2.6 What is Health?

As this research aims to understand the ways in which "culture" shapes health care experiences and access, consideration of cultural variations in the definition of health itself is required. A biomedical definition of health focuses on the absence of disease; in contrast, the World Health Organisation defines health more broadly, as: "the complete state of physical, mental and social well-being and not merely the absence of disease" (WHO, 1946). However, a non-biomedical conceptualization of health might also appropriately integrate religious, spiritual and sometimes the supernatural aspects of health, as in some Asian and African cultures (Weerasinghe & Mitchell, 2007). It has been argued that immigrants prefer such a holistic definition of health in contrast to the one normally used in Western biomedical health care (Dean & Wilson, 2010; Pavlish et al., 2010; Weerasinghe & Mitchell, 2007). Indeed a holistic view of health is preferred by some African-born immigrants and foreign-born people from Nigeria in Canada (Egharevba, Ibrahim, Kassam, & Kunle, 2015; Daniel A Offiong, 1999). The term 'holistic health' reflects the idea "that health is a positive state of functioning" and wellbeing (Guttmacher, 1979, p 15)Kopelman & Moskop, 1981) rather than (in a negative sense) simply the the absence of disease. From this perspective, health is the integration of the physical, mental, social, environmental and spiritual aspects of wellbeing – considering the totality of the individual (McKee, 1988).

There is a need for the provision of culturally competent health care which takes into account these and other worldviews of various immigrants in Canadian society. Culturally competent health care refers to "ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt et al., 2002, p. v). Marginalized individuals (including immigrants) tend to experience difficulties that may hinder their easy access or receipt of health care services; such barriers are discussed in the next section.

2.7 Access to Health Care Services in Canada

Over the last few decades, there have been growing concerns about hindered access to health care among the general population and other marginalized subgroups in Canada. A somewhat dated study in 2003 by Statistic Canada on the issue of accessing health care services in Canada illuminated the growing problem of hindered access to care. The study finds that most people experience a long wait time for specialised services, which can range from 3 months or less; about 90% of this was in the area of specialist visits or diagnostic tests and about 80% for non-emergency surgery (Sanmartin, Gendron, Berthelot, & Murphy, 2004). This study also reports an estimate of one in five Canadians experiencing difficulties in accessing immediate care for minor health problems and they also find that the major barriers to accessing health care services include: difficulties in getting appointments, long waits for appointment, long in-office wait times and difficulties in contacting physicians (Sanmartin et al., 2004, p. 10). The most cited barrier to accessing health care services is the long wait time, including waits for physician and other in-office appointments, emergency room visits, and diagnostic tests.

A Fraser Institute study of wait times reports that the total number of procedures people were waiting for in 2009 was about 694,161, which was a 7.5 percent improvement from the

2008 estimated procedure wait (Esmail, 2009); a more recent study of wait times by the Fraser Institute in 2015 finds that people were waiting for about 894,449 procedures across the ten provinces in Canada (Barua, 2015). Such procedures include; general surgery, radiation oncology, medical oncology, gynaecology, plastic surgery, general surgery, orthopaedic surgery, neurosurgery, cardiovascular surgery, urology, internal medicine, residual, ophthalmology, and otolaryngology. This shows a rise in procedure wait from that recorded in 2009 and thus, the wait time issue has worsened. Furthermore, for GP to specialist referral or treatment, the estimated wait time was about 16.1 weeks in 2009 (Esmail, 2009), but rose to 18.3 weeks in 2015. This worsened wait time is also the highest recorded historically in Canada (Barua, 2015, p. 17).

Prolonged wait times have been found to have a number of medical consequences on the patient that can result in prolonged pain, suffering, disability or even death in extreme cases; delayed diagnosis or treatment allows disease to advance, and this affects treatment options and eventual outcomes; in some cases the illness can become untreatable (Day, 2013, p. 45). Long wait times for diagnosis, test and or treatments also have financial effects on patients, since poor health status and resulting difficulties in carrying out daily activities can lead to loss of jobs, incomes, wages and salaries (Day, 2013). Moreover, long wait times operate as a disincentive to utilizing services – in other words, a barrier to utilizing care, because people may not seek out appropriate help when they need it, due to the perception of a long wait.

A US study also reports barriers to accessing health care included long wait times, lack of insurance, administrative cost, and administrative complexity related to paperwork and insurance payment restrictions (Schoen, Osborn, Squires, & Doty, 2013). Further, in the UK, a study on access to health care identifies barriers to health care including; physician referral issues, financial barriers – prescription medication, dental and eye care – as well as long wait list/ wait

times and so on (Gulliford & Morgan, 2013; Gulliford et al., 2001). These various barriers affect people in different ways at differing levels, and have a more profound impact on people depending on their social status; the most significant impact is on the most vulnerable people in the society.

The term "vulnerable population" has been used to characterize a group of individuals who are at risk of or more susceptible to poor physical, mental or social health (Aday, 1994, 1997; Rogers, 1997; Shi, 2000). Immigrants, for instance, are often classified as vulnerable under this definition (Aday, 1994, 1997; Gelberg, Andersen, & Leake, 2000; Rogers, 1997; Shi, 2000). Research finds that specific vulnerable populations (e.g., homeless, older adults, refugees , undocumented immigrants, etc.) experience barriers to accessing health care, such as lack of knowledge about services, proximity to available services, lack of required services / special needs and sometimes language or cultural barriers which negatively affect their health status and outcomes (Barr & Wanat, 2005; Goins, Williams, Carter, Spencer, & Solovieva, 2005; Marshall, Urrutia-Rojas, Mas, & Coggin, 2005; Martins, 2008).

Similarly, some Canadian research has focused on the particular ways in which gender, racial and social economic status influence access to required health care in this country. For instance, barriers to health care access for women are often related to gender-specific conditions, stemming from diverse situations related to health care policies, the medicalization of women's reproductive health and women's unpaid work as caregivers, all of which affect women's health care choices and overall health status (Angus et al., 2013; Bird & Rieker, 2008; Zimmerman & Legerski, 2010). Specific barriers to optimal health care as identified by women in one study include: communication barriers due to rushed service, limited availability and insufficient funding for women's health conditions, lack of and insufficient information about available services, lack of uniformity in diagnosis and treatment procedures and so on (Angus et al., 2013).

Research on social class/socio-economic status (SES) and access to health care also finds that despite the apparent universality of the Canadian health insurance as dictated by the *Canadian Health Act,* the social class or the socio-economic status of individuals negatively influences their access to health care services as well as their health outcomes (Dunlop, Coyte, & McIsaac, 2000; Lofters, Slater, Kirst, Shankardass, & Quiñonez, 2014). Impoverished populations in particular can experience significant barriers to accessing health care related to cost of transportation, prescription medication, stigmatisation and so on (Loignon et al., 2015).

In relation to race and access to health care, research shows that the experience of discrimination in the process of accessing health care services often serves as a barrier to future utilization (Pauly, MacKinnon, & Varcoe, 2009). Relatedly, there are qualitative studies exploring barriers to accessing health care service by Canadian Indigenous Peoples. For instance, one study reported that urban Canadian Indigenous peoples face racism, discrimination, and communication barriers which have over time resulted in in-frequent use or outright refusal to seek health care services (Kurtz, Nyberg, Susan Van Den Tillaart RN, & Mills, 2008). Indigenous peoples and more specifically Indigenous women experience various forms of racism in their interactions with health care professionals (Kurtz et al., 2008). For instance, since Indigenous women are often negatively stereotyped as child abusers by healthcare providers, one grandmother explained how this in fact led to over-utilization: she takes the kids to the hospital for every minor injury in order to have official documentation so as to prevent child apprehension on suspected abuse. That was her way of protecting her family from health care providers and social services, which previously worked together to take her own children away years earlier (Kurtz et al., 2008, p. 56). Other participants in that study felt they were being judged by health care providers as inferior and described blatant expressions of discrimination by

service providers who automatically assumed that alcohol or drug abuse was the cause of their ailment(s) (Kurtz et al., 2008, p. 57).

Furthermore, participants believed their health issues were often brushed aside as being figments of their imaginations, that is, rendering concerns psychosomatic; there were also few opportunities to discuss health concerns with physicians (Kurtz et al., 2008). One participant stated that she had stomach ache which her physician brushed aside as phantom pains from past sexual abuse which after seven months of managing was diagnosed with cancer after her uterus was bloated and the pain was unmanageable. She expressed that the severity of the situation would have been diminished if her physician had taken note of her complaints (Kurtz et al., 2008). Coupled together, all these forms of barriers along with the general long wait time in Canada can lead to a refusal to seek health care or to using health care as a last resort after alternative healing/ remedies practices have been sought without result (Kurtz et al., 2008, p. 58).

2.8 Barriers to Accessing Health Care Services

Specific groups of people tend to experience greater barriers that hinder their optimal access to health care, which subsequently shapes their health status and their future approaches to utilising health care services. In relation to health care, the term "access" refers to the potential and actual entry into the health care system as well as the utilisation of health care service by persons that require such services or persons that have health care needs (Gulliford et al., 2002). Thus, optimal access to health care should be facilitated by "helping people command appropriate health care resources in order to preserve or improve their health" (Gulliford et al., 2002, p. 22). Barriers to accessing health care services refer to factors that hinder an individual's effective and optimal access to the required health care services or resources; such barriers can be structural/organisational, personal or socio-cultural in nature. A number of research studies

find that immigrants do experience barriers in accessing health care services in Canada; several of these studies are reviewed below.

2.8.1 Foreign-born Residents and Access to Health Care Services in Canada

Existing research shows that immigrants can face quite a number of barriers in relation to both health status and health care service that are related to complex interactions of forces, such as social and economic conditions (Dunn & Dyck, 2000; Kinnon, 1998) as well as other processes more specifically influencing access to and utilization of care. This study aims to contribute to a growing body of knowledge on issues of access and utilisation among Nigerian immigrants and temporary residents in Canada. Some barriers faced by immigrants in accessing health care services in Canada as suggested in qualitative studies include: poor language skills (Dastjerdi et al., 2012; Newbold, Cho, & McKeary, 2013); high cost of prescription medication (Asanin & Wilson, 2008); lack of health insurance (Asanin & Wilson, 2008); lack of social networks (Dastjerdi et al., 2012:5); lack of knowledge about the health care system; discrimination (Dastjerdi et al., 2012); long wait times (Asanin & Wilson, 2008; Newbold et al., 2013); and lack of culturally appropriate services (Dastjerdi et al., 2012); (Weerasinghe & Mitchell, 2007). Furthermore, barriers to accessing health care services among the temporary workers population in Canada include: lack of health insurance, language barriers, transportation issues, fear of repatriation, lack of information about health care services, long wait-time, lack of cultural sensitivity (Hennebry, 2010; Hennebry et al., 2016; Preibisch & Hennebry, 2011). For international students in Canada, some barriers to accessing health care services include: lack of knowledge about the health care system and health insurance, triage issues, long wait time, transportation cost to clinics, and divergent understandings of medication use, linked to the belief held by international students that they must have medicine to get better or feel cared for (Burgess et al., 2016).

2.8.2 Outcomes of Barriers to Health Care among Foreign-born Populations

Barriers to accessing health care may play a role in the overall health of the immigrant population by contributing to declines in health status through both psychosocial pathways (frustration, feelings of exclusion) and unmet health care needs. For instance, due to lack of knowledge about how the Canadian health care system operates, Iranian immigrants in one study faced unmet needs for health care, since they often did not know what to do when they required health care or felt unwell (Dastjerdi et al., 2012). This can be compounded by cultural background, wherein health issues are often not shared publicly – as a result, health care needs may not be disclosed until these immigrants are personally asked (Dastjerdi et al., 2012).

Among the temporary resident population in Canada, studies on temporary workers and international students also revealed that the lack of information/ knowledge about the health care system serves as a barrier to accessing health care services. For temporary workers, studies have found that they were often confused about the proceedures, loctions/ clinic hours, as well as their specific entitlement which caused them to delay their health care needs (Hennebry et al., 2016). Among the international student population, a study of female international students found that they often lacked adequate information regarding the locations of clinics, health insurance use and coverage, and health care procedures (e.g., triage). As a result, most participants had a fear of falling ill and often self-medicated using drugs gotting from their countries of origin despite lack of proper understanding of the directions of use for all their medications as they were often without prescriptions (Burgess et al., 2016).

Further, among a female immigrant/refugee claimant group (women from various source countries i.e. Columbia and Iran) in Ontario, Newbold et al. (2013) find that language barriers and lack of adequate interpretation services were significant obstacles to accessing required

health care services. Issues surrounding language and interpreter services also served as a barrier to accessing health care services among the temporary (agricultural) workers in Canada as it often placed them in vulnerable situations where they have to depend on their employer for interpretation and this compromises their health information privacy (Hennebry et al., 2016). This lack of interpreter services can lead to serious miscommunication of treatment instructions, as well as appointment and health information, which can frustrate patients, causing them to decline further treatment.

The high cost of prescription drugs and a lack of health insurance can also negatively affect immigrants' experience in accessing and receiving health care in Canada (Asanin & Wilson, 2008). Further, the provisional health insurance that does exist does not cover prescription drugs, dental care and eye care; those who cannot afford these costs or private insurance may avoid using these services (Asanin & Wilson, 2008). As a result, upon their migration, immigrants are placed in a vulnerable position as their health care solely rests in their hands and is not covered by the government.

Dastjerdi et al. (2012) notes that hospital staff are not culturally sensitive in their relations with "non-white English-speaking immigrant" patients, which leads to feelings of discrimination and being ignored that causes them to avoid seeking health care services for illness, potentially risking their health. Also, immigrants from various source countries (mostly in South Asia and East Europe) in another study reported dissatisfaction with the Western biomedical approach to health which was quite different from their own holistic understanding (Asanin & Wilson, 2008). Likewise, another study of immigrant women (from various source countries in Asia, Africa, Latin America, and "Non-English speaking Europe") in Canada suggested that not only might health providers fail to provide culturally sensitive health care services, but that sometimes

immigrant patients and their doctors hold different understandings and explanations of illness as well as problems and solutions (Weerasinghe & Mitchell, 2007). This dissatisfaction can negatively affect immigrants' overall health and is compounded in situations where immigrants do not trust doctors to listen to their problems. In one study, immigrants from Iran tended to ignore their health care needs rather than receive treatment from physicians whom they do not know and trust, especially when their choices and negotiations – on treatments and specialist physicians – were restricted by family doctors (Dastjerdi et al., 2012). Similarly, a study of temporary workers also found that the insensitivity of health care providers often led to perceptions of substandard care due to their failure to acknowledge health concerns or treat them adequately which resulted in their unwillingness to seek health care services when required (Preibisch & Hennebry, 2011). The experience of barriers to accessing health care services is not restricted to immigrants in Canada alone, however, as will be illustrated in the next section, which focuses on other studies of barriers to accessing health care among immigrants in other (i.e., not Canadian) developed and western countries.

2.8.3 Foreign-born Residents and Access to Health Care Services in US and UK

Various studies show that immigrants often experience and report a number of barriers in the process of gaining access to health care services in other host countries. For instance, a study on Hispanic immigrants in the United States reveals that lack of knowledge about the structure of the health care system ultimately affects immigrants' experiences with seeking professional health care due to uncertainty about which type of help to seek for specific health problems (Liebert & Ameringer, 2013). This could occur most especially in situations where immigrants have a preconceived holistic perception or understanding of health care. In the United States, immigrants are generally unaware of the availability of free or low-cost health care providers because these are not advertised but passed around by word of mouth; as a result, they are left

out of the ‘information loop’ (Liebert & Ameringer, 2013). Another study of Southeast Asians in the US similarly finds that they are mostly uninformed about the available health care services as their needs are often underestimated and thus many social agencies do not provide adequate or sufficient information about the health care services available (Uba, 1992). In relation to international students, a qualitative study – focus group –of int ernational students in the US also found that they were often uninformed about the health care system and how to utilize it, especially about the health insurance system and this was a source of major confusion (Poyrazli & Grahame, 2007)

Further, in a U.S qualitative study of Latino immigrants by Harari, Davis, and Heisler (2008), language barriers negatively affected immigrants’ access to health care. Language barriers cause anxiety in immigrants seeking professional assistance – they need interpreters to help them successfully navigate the system and understand their treatment, yet are sometimes unaware of the availability of interpreter services and their rights to use these. As a result, their health status is negatively affected, and in most situations, suffering is unnecessarily prolonged.

Moreover, research in the United States on Hispanic immigrants confirms the importance of a lack of health insurance as another important barrier to health care as it bars an individual’s access to health care due to limited or lack of coverage (Cristancho, Garces, Peters, & Mueller, 2008). A study by Harari, Davis, and Heisler (2008) in the United States reiterates this finding as they note that lack of insurance created anxiety among Latino immigrants (from Central and South America source countries), which affected their decisions about whether or not to seek professional health care. This research also reports that new immigrants often lacked knowledge about how to navigate the system and sometimes had preconceptions about receiving substandard care without insurance. Liebert and Ameringer (2013) also note that native-born Americans have an 85% insurance rate

in comparison to 46% for immigrant residents. For undocumented immigrants in the US there is almost no option for purchasing health insurance; a study of undocumented Latino immigrant women in the US finds that 91.1% of participants do not have any health insurance and were thus less likely to seek treatment or medication for their health problems (Marshall et al., 2005).

In another study, it was reported that African immigrants had divergent expectations and views about their health care needs than those of their physicians in China (Lin et al., 2014); these participants expressed dissatisfaction with health care stemming from discordant beliefs and health care practices, including rushed, non-patient centered care, and privacy violations; this situation was compounded by language barriers (Lin et al., 2014).

A few studies in the U.S have found that immigrants may also experience discrimination on the basis of their racial identities. Foreign-born residents from different racial and ethnic groups are more likely to face discrimination than their native-born counterparts. (Lauderdale et al., 2006; Pavlish et al., 2010). Lauderdale et al. (2006) finds that racialized immigrants face greater discrimination than even native-born persons of similar racial or ethnic backgrounds. This study finds that place of birth – being foreign-born – is associated with significant increases in reports of discrimination for Asian and Latin-American individuals; among Blacks/Africans, however, foreign birth had no influence on the experience and reports of discrimination in health care, as both foreign-born and U.S born Blacks reported significantly high level of discrimination (Lauderdale et al., 2006). Moreover, among the Caucasian/White group foreign birth also had little to no influence on reports of discrimination but in this case because both groups reported low levels of discrimination (Lauderdale et al., 2006). Consequently, Lauderdale et al (2006) posits that being foreign-born and of a minority racial/ethnic group may increase the likelihood of perceiving or experiencing discrimination in health care; this may be due in part to the

divergence in understandings of health and resulting dissatisfaction in service receipt borne from cultural diversity.

Furthermore, a qualitative study of African immigrants from Ghana, Nigeria, Togo and Sierra Leone in China explores experiences of racism in interactions with the health care system and providers in China (Lin et al., 2014). Participants perceived that Chinese doctors avoided touching them due to fear of contracting African diseases, or assumed that they were drug abusers. These participants also believed that Chinese physicians gave preferential treatment to Chinese patients before any other racial group without consideration for their time of arrival. Indeed, biases or stereotypical beliefs held by both the health care providers and patients can infuse the delivery of health care services and perceptions of the health system in general. Perceived health care discrimination can influence immigrants' views of the health care system and thus potentially influence their choices about future utilisation of formal services (Lin et al., 2014).

In specific relation to African immigrants' health care experiences, a qualitative study of Somali immigrant women in the United States found that this group had health beliefs and treatment expectations which diverged from that of their physicians, which was symptom focused and fragmented/non-holistic (Pavlish et al., 2010). Participants also reported feeling rushed in their interactions with physicians (Pavlish et al., 2010). Consequently, these authors conclude that Somali immigrant women's experiences with the U.S health care system were characterised by a series of unmet expectations, as their perception of health was more holistic and contextual in nature in the face of the fragmented American health care system. This disparity in health beliefs between physicians and patients impaired the health care satisfaction and experiences of Somali immigrant women in the United Kingdom in another study (Warfa et al., 2006), since their health practices were influenced by their culture and more often than not,

health care providers did not understand their cultural beliefs. Furthermore, a study of international students in the US also found that the cultural beliefs of participants (international students) had major influence as it could serve as a barrier to seeking health care services especially in reltion to counseling or mental health services (McLachlan & Justice, 2009). This finding indicates that the culture and beliefs of patients plays a a major role in the health decisions of foreign-born individuals and as such it is important for health care providers to utilize cultural sensitivity in their health care delivery approach.

2.9 Culturally Competent Health Care Services in Canada

The issue of culture as a barrier to accessing health care services is quite significant; culture influences the peoples' perception and reception of the health care services provided especially in situations where cultural differences are ignored. There is therefore a need for the provision of culturally sensitive/competent health care services to patients, including newly arrived and immigrant populations. A number of studies examine the phenomenon of culturally competent health care service provision. Cultural competence refers to systems, agencies or professionals that practice inclusive behaviours, attitudes and policies, which enables them to function cross-culturally or in a multi-cultural society (Maleku & Aguirre, 2014, p. 562). In health care specifically, cultural competence has been defined as "the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural and linguistic needs" (Betancourt et al., 2002, p. v). In essence, it aims to meet the diverse and specific needs of culturally diverse populations by taking into account the role and importance of culture, by assessing cross-cultural relations and noting differences between the diverse cultural groups at all levels of interaction. A culturally competent system is, moreover, "built on an awareness of the integration and interaction of

health beliefs and behaviours, disease prevalence and incidence, and treatment outcomes for different patient populations" (Betancourt, Green, Carrillo, & Ananeh-Firempong 2nd, 2003, p. 294). Consequently, the aim of providing culturally competent health care is to ensure every patient receives optimal care as quickly as possible when needed without any barriers arising due to their racial, ethnicity or cultural background, or language proficiency.

Findings from research on cultural competence in health care delivery have some implications for the health care system, suggesting improvements are needed in other to improve the health outcomes of immigrants. This includes, first, the promotion of health literacy which involves the ability to obtain, process and understand basic health information and by virtue of this make the necessary health care decisions (Maleku & Aguirre, 2014). This can be achieved by developing health information for patients at their literacy level with specific consideration of the language and cultural norms of the population. Providing interpreter services when needed is also a step in promoting health literacy (Betancourt et al., 2002).

Second, cultural competence includes the expansion of cultural/linguistic competence within the various health professions, as research shows that this leads to better patient outcomes (Maleku & Aguirre, 2014). This can be achieved by providing cross-cultural training for providers in other to educate them on the impact of social and cultural factors on health beliefs and behaviour (Betancourt et al., 2002). Third, cultural competence entails increased diversity in the health care workforce as this helps reduce racial disparities; a culturally diverse workforce can best serve underserved minority communities (Maleku & Aguirre, 2014). Diverse workforces include minority groups members in leadership positions in health care delivery systems as managers, senior managers, boards of trustees and staff (Maleku & Aguirre, 2014).

Another step can be hiring internationally trained health care professionals that have completed specific local health care training.

Lastly, health care provision should be patient-centred, with the focus being on the patient and not solely on the disease. This would help bridge the gap between healthcare professionals and their patients as it encourages them to view patients as persons and build understanding between them; dignity, respect, participation and collaboration is encouraged. Thus, the health care system and professionals would need a more holistic outlook on health care services and patients' health care needs (Maleku & Aguirre, 2014, pp. 577-578).

In summary, immigration to Canada has risen in recent times, and with it, there is a need for the provision of appropriate settlement services; the immigrant population has become increasingly diverse and includes migrants from different continents and source countries. Among migrants to Canada from the African continent, Nigeria ranks highest as a source country. In the face of migration and settlement, immigrants often face barriers related to access to employment, social services, health care and so on that impede their optimal and easy transition into their new host country.

Especially important is access to healthcare, as it is an important influence on the quality of life of an individual, and hindered access to health care can negatively compromise both the health status and productivity of individuals. Despite the growing rate of immigrants to Canada from Africa in general and Nigeria in particular, there is little research on newly arrived Nigerians' experience in the Canadian health care system in relation to accessing and receiving health care services. Studies of health care access among other immigrant groups (from Asia, Non-English speaking Europe, Latin America, and so on) in Canada reveals a number of access barriers which includes; language barrier, high cost of medication, long wait times for care,

health insurance issues, discrimination, lack of culturally competent services, and so on. In order to mitigate settlement issues arising from hindered access to health care services, there is a need for the provision of culturally competent health care services and the practice of cultural competence in interacting with patients thereby creating a more inclusive system.

CHAPTER THREE

Methodology

This chapter outlines and describes the research – data gathering and analysis process – while also describing ethical considerations. This research utilises a qualitative interview method to explore participants' experiences while also considering their cultural backgrounds, in order to examine the meanings of health and health care that are embedded in Nigerian immigrant groups. In addition, I draw on some of the theoretical elements of the critical race and anti-racism frameworks, for instance as applied by Kereyo and Flomo (2012), which are helpful for understanding the broader contextual roots of problems related to accessing suitable health care services. This is of importance as this research examines how immigrant status and cultural interpretation shape Nigerian immigrants' experiences in accessing health care in Canada.

3.1 Research Design

My research examines Nigerian immigrants' interpretations and experiences in accessing and receiving health care services in Canada. The research question involves "the description of subjective meanings attributed to situations and action," and as this is an area of qualitative research, this drove my decision to select qualitative research as the method of inquiry for this study (Fossey, Harvey, McDermott, & Davidson, 2002). In its process, qualitative research is quite flexible and responsive (i.e., iterative), and a particular study's research question could, in fact, evolve during the process of ongoing analysis (Fossey et al., 2002). Thus, the aim of this research is to generate insights into or better understand the barriers – if any exist – which this immigrant group faces in gaining access to health care in Canada, by drawing on an exploratory qualitative interview approach. Thus, this study focuses on the lived experiences of research

participants in order to gain an in-depth understanding of their experiences within the Canadian healthcare system. Also, in its conception qualitative research is concerned with the active interpretation of subjective meanings, and rich description of social contexts in which research participants are embedded, as well as privileging their lay knowledge and lived experiences (Fossey et al., 2002). It also involves an inquiry process that is interested in "understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting" (Creswell, 1994, pp. 1-2)

Qualitative research in a broader context involves the study of social life in a natural setting or place in which daily events occur (Savage, 2006). These factors and contribution of the qualitative method make it the most suitable method for analysing and exploring the research question. Furthermore, in health services research, qualitative methods have been used by researchers essentially in studying phenomena as they naturally occur (i.e., not in an experimental or statistical context) to gain an understanding of such phenomena and how these are given meaning by participants (Savage, 2006).

3.2 Participant Recruitment

In alignment with the goals of qualitative research (wherein statistical generalizability is not the goal), I used a blend of nonprobability purposeful/convenient sampling (including snowball) sampling approaches. The purposeful/convenient sampling strategy involves studying whichever member of the desired population is easily available, with the goal of producing a sample that embodies the required criteria for the research (Blair, Czaja, & Blair, 2013). Thus, I sought participants who fit the analytical criteria required for the goals of this study and data was gathered until no new information was derived. The purposeful recruitment strategy helped

ensure that the participants were appropriate for the analysis or research. Data richness was sought and derived in eliciting and recording detailed descriptions of participants' specific health care experiences (Morse, 1995).

Specifically, I recruited both male and female Nigerian-born participants who self-identified as immigrants to Canada, with either an acute or chronic condition, who had at least one visit to the hospital, walk-in clinic or GP (family doctor) since their relocation to Canada. Participants were all recently arrived from Nigeria and were 18 years of age or older (to be considered legal adults able to provide informed consent; also, the focus of this research is not minors). Participants were eligible if they had resided in Canada for no more than 5 years because this research is concerned with the health experiences of recent or first-generation immigrants, and especially foreign-born Nigerians who are in the process of settling in Canada.

International students were included in this study and make up the majority of the participants; although they are more accurately characterised as temporary residents who occupy a more liminal status in Canada and who may or may not decide to (or be able to) obtain permanent residence, it is noteworthy that all of the participants self-identified within the 'immigrant' category (as indicated in the various recruitment posters for this study). These participants also indicated in their talk their intentions of seeking and pursuing a permanent residence status upon the completion of their education. As a study group, the health care experiences as well as the health status of international students have not been fully explored. As such, the finding from this research could contribute to the available body of research on international students (from Nigeria), especially in the area of their experiences in gaining access to the health care services in Canada.

In order to recruit participants, I contacted various Nigerian immigrant associations in Winnipeg via recruitment letters (Appendix III) and had my recruitment posters (Appendix IV) sent to their membership mailing lists such as: The Nigerian Association of Manitoba, Nigerian Professionals in Manitoba and Igbo Cultural Association of Manitoba. Furthermore, participants were recruited from a Nigerian church where it was made known through an announcement that I required study participants and interested parties contacted me directly. Also, study posters were placed in a community centre, on the notice board at the University Centre in University of Manitoba and through referrals from other participants (the latter was the most successful recruitment method). When participants indicated interest, the consent form (Appendix II) was sent to them, and then the interview was scheduled.

As noted above, participants were required to have experience accessing health care in Manitoba, specifically in Winnipeg and not any other provinces or cities in Canada (which may have different health care systems). Also, the participants must have had a minimum of one visit to health care facilities in other to be included as I aimed to recruit those most able to talk about experiences with health care. Also, the participants must have had experience with the Nigerian health care system in other to be able to make comparisons between the two health care systems. As a result they must have resided in Nigeria and be born in Nigeria.

My research consisted of a total of nine participants (of which six were international students and three were permanent residents) and this total number was determined by the availability of participants and the principle of "saturation" (Bradley, Curry, & Devers, 2007; Glaser & Strauss, 1971; Hallberg, 2006), which is indicated by the filling of all gaps in the data or repetition, that is, when no new concepts or information emerge from data gathered from the sample. Although the number of participants is arguably small, this was counterbalanced by the

collection of extensively rich and quality data from participants, which is filled with details of participants' experiences, including numerous stories and examples that are relevant to the study. As Morse (2000) argues, if the research topic and question is clear, easy to understand or relate and the required information can be derived through individual interviews, then such research would require fewer respondents/participants than other studies.

3.3 Data Collection

In order to attain data that is on target, rich, and experiential in order to answer my research question, I used the semi-structured interview with an interview guide (Appendix I) that contained questions, question categories, and prompts to help with the collection of relevant data and direct the overall interview process. The interview process utilised a face-to-face qualitative interview method (once per participant) consisting of a back and forth conversational process involving "researchers asking questions and listening, and respondents answering" (Warren, 2002, p. 83). Interviewing is suitable for exploratory research and approaches participants as "meaning makers" with attention to the interview interaction, and to participants' experiences and life worlds (Warren, 2002, p. 83). This approach will help fill existing knowledge gaps about Nigerian immigrants' and temporary residents' lived experiences, perceptions, impressions and interpretations of health care access and delivery and the health care system. During qualitative interviews the standpoint or perspective of the participant can shift to reflect differing social positions – such as when participants recount past experiences as a "former child, then as a mother, then as an employee", and so on (Warren, 2002, p. 84); this is an important aspect of how participants create meaning.

As interviews are social constructions (Warren, 2002), I considered how participants talk about their experiences and kept detailed field notes about all stages of the data gathering and the

interview process. These field notes or memos contained my personal reflections and details about the overall research process and analytic decisions, to ensure rich rigour (Bacsu et al., 2012). Interview field notes were used to provide context for the research as they aided in generating themes and categories as well as in interpreting the data. All interviews were conducted by me personally; interview talk was recorded using a voice recorder with participant's consent and I personally transcribed the recordings. Hard copies of the transcripts were kept in a locked cabinet in my research supervisor's office. Password-protected computers were used in data management and creating the interview transcripts.

3.4 Participants

A total of nine (9) participants – 3 male and 6 female – were interviewed at either the University of Manitoba (5) or the participants' home (4). All participants had a minimum of high school education with a majority being in the process of gaining their undergraduate degree or master's degree (e.g., those with international student status). The age of participants ranged from 20- 49 years and all participants had had a minimum of one visit to a health care facility since their relocation to Canada. Also, all research participants had resided in Canada for between one (1) to three (3) years. Participants were also from the three major regions in Nigeria - Northern (1), Eastern (1), and Western (7) regions, and they were all Christians excluding one participant (Tobi) who identifies as a "Chrislam" (that is, he practices Christianity and Islam). See Table 1 for more detailed demographic information. Pseudonyms have been included to replace participant names.

Table 1: Demographic Characteristics of Interview Participants

Pseudonym	Occupation	Immigration Status	Gender	Years in Canada	Socio-Economic Status	Age
Tobi	Student Researcher	International Student	Male	2.5yrs	Middle-Upper	32 years
Dayo	Graduate student	International Student	Male	2.5yrs	Middle	32 years
Funto	Mother/ Volunteer	Permanent Resident	Female	3yrs	Middle	49 years
Amira	Nursing Student	International Student	Female	3yrs	Middle	22 years
Bunmi	Mother/ caregiver	Permanent Resident	Female	2yrs	Middle	32 years
Dotun	Worker	Permanent Resident	Male	3yrs	Middle	40 years
Ijeoma	University Student	International Student	Female	2yrs	Middle-Upper	20 years
Yemisi	Biomedical Student	International Student	Female	1.5yrs	Middle	25 years
Nike	Science Student	International Student	Female	2.5yrs	Upper	20 years

Three additional persons who were recruited to participate in this study were eventually not included as they were unavailable for an interview after repeated attempts by the interviewer to schedule these (participants cited personal reasons, and an inability to make prescheduled appointment times).

I interviewed all participants once and the length of interviews ranged in time from between 1 hour and 1 hour 30 minutes including time to review the consent form and address participant's concerns. The interviews were conducted from the 18th of May 2016 till the 28th of October 2016. All interviews were audio recorded with the consent of the participants and the

transcripts and field notes written after these interviews served as the primary data used in this research.

3.5 Data Analysis

Data were analysed through several commonly used qualitative approaches to coding, constant comparison, and interpretation. Coding involves the simplification and complication of data and was used to breakdown, classify and categorise the data, and then to generate new concepts that are linked to theories (Coffey & Atkinson, 1996). This process helps in the transformation of and thinking about the data in the research process. Coffey and Atkinson (1996) note that "coding may be part of the process of analysis, it should not be thought of as the analysis in itself" (p. 26). Thus, elements of constant comparison and interpretation were also used to complement the coding process. Constant comparison is a concept linked to grounded theory (Charmaz, 1990) and it involves comparing data to data, categories to categories and concepts to concepts. In this research, constant comparison involved "comparing different people's situations, beliefs, behaviour or accounts of the same type of event or issue … and comparing properties found in the data with other properties" (Charmaz, 1990, p. 1168). Therefore, I compared the participants' experiences with one another in order to note the similarities and differences in the talk and derived concepts and categories, and ultimately to yield deeper understanding of the issue. Interpretation here involves noting the similarities, irregularities, differences and exceptional experiences in the data while also noting the systematic relationships between and among categories and concepts (Coffey & Atkinson, 1996).

These methods are suitable forms of analysis for this study as the research data were derived from participant interviews and as a result, were in the form of interview transcripts and interview/ field notes. These methods of analysis enabled me to compare, contrast, view and

interpret participants' responses both individually and as a group, which aided in revealing similarities, differences and uniqueness in perceptions and experiences between participants, and thus helping with the interpretation of the findings.

The research findings are organised into a number of sections that present analyses of major themes and concepts. This includes analyses of participant data related to the following: pre-migration expectations/experiences, post-migration experiences, understandings of health, experiences of accessing health care in Nigeria, and lastly, experiences in accessing health care in Canada.

3.6 Ethical Considerations

The recruitment of participants for this research began after the approval of ethics board was granted. The Ethics approval was obtained through the Research Ethics Board of University of Manitoba (Appendix V). I made sure to safeguard participants' privacy by ensuring confidentiality of data at all times from the transcription stage to the analysis and findings stage. In order to protect the confidentiality of the participants all interviews (and transcription) were conducted by myself. I was also alert for deductive identifiers which may render participants identifiable due to their unique traits or other characteristics (Kaiser, 2009). Some examples of deductive identifiers in this research could be, in the case of students, combinations of the name of their university, course of study and degree, as this would render participants identifiable when taken in conjunction with being a Nigerian immigrant. Furthermore, in order to protect the participants' identity I also utilized pseudonyms to replace participants' names; these pseudonyms were used when participants were quoted directly in the following chapters. Other personal information was also de-identified (e.g., specific complex health conditions, the names of specific clinics or particular health care providers and their staff). All digitally recorded

interviews and transcripts were number coded and stored on a password protected computer which was only accessible to myself and my thesis supervisor. The hard copies of the data (i.e., transcribed interviews, informed consent forms) were locked in my Thesis supervisor's research office (Dr. Funk, 301L Isbister).

All interviews were conducted at a convenient location which was agreed upon by myself and the participants. All interview locations were safe and private – participant's home or office at the University of Manitoba. The informed consent of participants was obtained before the interview started (Appendix II) and participants were informed of the audio-recording device. Participants were also informed that they could choose to stop the interview at any time and also decide on whether the information provided to that point might be deleted or included in the research. Participants were given the option in the consent form to indicate their interest in receiving a summary of research findings either by E-mail or post. Participants were all offered a $10 honorarium (in the form of a grocery gift card) although only one participant wished to accept this.

Both my supervisor Dr. Funk and myself have completed the CORE tutorial and the additional PHIA documentation and are well trained in handling private health information and in ensuring participants confidentiality. For instance, during the transcription process, all interviews and transcripts were assigned code numbers that correspond to each other in other to ensure participants' anonymity.

Due to the fact that the interviews required participants to discuss past experiences, there was the possibility that participants might have negative emotional reactions to traumatic experiences. On account of this, I ensured to take into consideration of the sensitivity of the subjects during the interviews and was alert for signs of emotional reactions and upset in

participants. Also, a list of available psychological counselling services was made available for participants although no participant required it.

3.7 Limitations of Research

This research has a number of limitations as it is qualitative in nature and studies the health care experiences of a small number of persons from one African source country population – Nigeria – in Canada. First, the findings from this research are not statistically generalizable beyond the study participants, who were newly arrived Nigerians in Winnipeg, Manitoba. Although one of the aims of this study was to explore the experiences of newly arrived Nigerian-born residents in Canada, the applicability of this research is further limited because as well as permanent resident immigrants, the majority of participants were international students, who have a more liminal residence status in comparison to immigrants who arrive through other processes.

Moreover, participants had lived in Canada for about 1 to 3 years and were between the ages of 20 to 49 years. The experiences of older adults were excluded from the research due to the inability to recruit anyone in that age group. The data are thus not representative of the broader Nigerian population in Canada or Winnipeg. However, since the goal of this research was a rich, in-depth exploration of data and experiences rather than statistical generalizability, it is hoped that this research helps lay a foundation for future research on African/Nigerian-born residents' experiences in relation to health and health care.

CHAPTER FOUR

Findings Part 1

In these next two chapters I present the findings from the interviews, which have been organised into five sections. The first section (Chapter Four) examines the migration history of participants, specifically focusing on their pre-migration expectations and experiences. The second section (Chapter Four) examines participants' post migration experiences. The third section (Chapter Four) explores participants' understanding of health (specifically, what it means to be healthy or unhealthy). The fourth section (Chapter Five) examines participants' impressions of health care in Nigeria and finally the fifth section (Chapter Five) examines participants' impressions of health care in Canada, with a specific focus on their access to health care services. I then conclude with a brief summary of the findings (Chapter Five)

4.1 Migration History

All participants interviewed in this research relocated and settled in Canada within the past three years; the main focus of this research is on recent immigrants to Canada (those that have resided in Canada for a maximum of five years). This albeit narrow definition was intended to facilitate close examination of how participants' recent pre-migration histories and experiences may shape their current experiences with Canadian health care. Moreover, it targets those who may be more actively experiencing settlement challenges.

Participants stated several factors that precipitated their decision to relocate to and settle in Canada, and these include: better educational system and attainment; better life style and opportunities; and family reunification; to a lesser extent the media portrayal of developed countries may have played a role. For instance, six participants who are currently pursuing an

academic degree indicated that the pursuit of better education specifically influenced their decision to relocate. In the following quotation, a participant expressed the largely held opinion that developed countries have better educational systems and students receive better training for their future endeavours:

> I wanted to study computer and um my parents or my dad rather decided that it was best for me to study abroad instead of studying computer science in Nigeria because it was going to be theory based in Nigeria but abroad it is practical, more practical (Nike; Female, International Student age 20, 2.5 years in Canada).

Amira also reiterated this point of higher education while also indicating a desire to stay in Canada: "I came to Canada for better education, I came to learn more in a foreign land, because I know Canada has good educational systems, so I just came for university, and hopefully, will stay after school" (Female, International Student, age 22, 3 years in Canada).

The other three participants who are not pursuing any specific academic endeavour indicated that the desire for a better life and opportunities for their families drove their decision to migrate and settle in Canada. Funto specifically spoke about her belief in the superior and better life that is available to residents of a developed country. The following quote by the participant illustrates her belief:

> I came to Canada because I know that life in western countries cannot be compared to um the state of living in a developing country. So because I want a better life for myself and my family, so [we] moved to Canada. (Female, Permanent Resident, age 49, 3 years in Canada)

This belief of better lifestyles and opportunities for Canadian residents was echoed by two other participants that specifically stated why they chose to relocate to Canada, as in the following response: "… just in the quest for a better life if you say so. It's a developed world and then you look at the opportunities that you might get and your generations to come. So it just felt like the

right place to come to at that time" (Bunmi, Female, Permanent Resident, age 32, 2 years in Canada). More specifically in relation to better opportunities, Dotun stated that: "… number one it is the quality of life that exists here. The possibilities of opportunities for personal development and becoming established in one's career and raising family in a very structured and organised environment" (Male, Permanent Resident, age 40, 3 years in Canada).

Another factor that appeared to influence migration decisions is family reunification. Two participants indicated that they have family members who currently reside in Canada, while one specifically stated that his sibling is a citizen and this aided his permanent resident status. Quotes from these participants illustrate this. For instance: "Well I came to Canada in 2014. I came via the provincial nomination, my elder brother is also in the province. He has been living in the province for over five years. He is even a Canadian citizen" (Dotun, Male, Permanent Resident, age 40, 3 years in Canada). Nike stated that this aided her parents' decision to let her migrate to Canada for her post-secondary education in the following quote: "… and two of my sisters were already here so they said why not come to Canada?" (Female, International Student, age 20, 2.5 years in Canada). Nike further revealed that her migration to Canada for higher academic pursuit and settlement was not without worry. She also expressed that her mother had serious concerns about her relocation due to her age at the time (a minor at 17 years) and also issues surrounding negative peer influence. Her quote illustrated this parental worry: "My mum was against it at first, she was like I am too young. You know, influence and everything, peer pressure. I was like, know the daughter you have (*Laughs*) and that kind of convinced her and here I am" (Female, International Student, age 20, 2.5 years in Canada). This quote illustrates that a measure of parental trust in their child's ability to settle in Canada also contributed to a positive migration decision.

Overall, participants had high expectations in relation to their intent on migrating to Canada, especially with respect to higher educational attainment and better opportunities. This is important as participants' expectations contribute to their settlement experiences specifically in relation to whether or not their initial expectations were met upon migration; this is examined in the next section.

4.2 Post-Migration / Settlement Experiences

All participants had resided in the Winnipeg area and they expressed a number of experiences, both positive and negative, which have influenced their settlement in their new environment. Three participants described the availability of social amenities and infrastructures in a positive light as this enabled them to meet their daily needs and influenced their standard of living. In relation to electricity, the following quotes by two participants illustrate the availability of good power supply in Canada as compared to Nigeria, where the power supply can be described as unstable and inconsistent: "Well, first of all there is constant electricity. So yeah it's good." (Yemisi; female, International Student, age 25, 1.5 years in Canada). Tobi also mentioned a specific use of electricity in the following quote: "… ultimately I don't plan to iron my clothes for the week so it's very good" (Male, International Student, age 32, middle-upper class 2.5 years in Canada). This is salient as in Nigeria, due to the fluctuating power supply, people have to plan their clothes weekly and iron/ press them - especially workers and students who are required to present a tidy and professional image. In Canada, constant and stable electricity means that participants were relieved about not needing to worry about ironing clothes until needed.

Also in relation to infrastructure, Tobi also mentioned a number of services such as health care, transportation, and education in a positive light when compared to the infrastructure available in Nigeria, in the following quote:

> It is good because when I compare to where I am coming from, the fact that I can get access to health care with little or no cost make[s] it very good. The fact that I can sit in my home track the bus, get to a place at a certain time without delay I would say it is very good, the fact that I can have access to education … academic year without interruption by maybe students' strike or university strike or labour strike also is very good, the fact that I can just go out, get what I want easily is very good (Tobi; male, International Student, age 32, middle-upper class 2.5 years in Canada).

In contrast, another participant expressed a differing view of the public transportation system (bus) in Winnipeg. Specifically, Yemisi had issues with the unprofessional conduct and "lackadaisical" attitude of the bus drivers. She painted a scenario where bus drivers stop en route to get coffee at Tim Horton's or 7-11 without informing the passengers of the route change or delay and not considering that the passengers might be trying to meet up with a connecting bus to their end destination. She also described an unacceptable situation where people have to stand outside in the heat or cold at bus stops without shades and the bus drivers arrive late or miss the connecting bus. She compared this with Lagos in Nigeria by stating that even though the public bus system in Nigeria is not as organised, the bus drivers still inform passengers of unplanned stops or route changes (Female, International Student, age 25, 1.5 years in Canada).

Further, two female participants shared their disappointment at the level of infrastructure development in Manitoba and Canada, stating that the services and systems did not meet their expectations for the country. Bunmi stated: "It wasn't far from my expectations, but it was actually surprising that the [Level of] development in Canada I feel is not as developed as you will expect it to be. Because I have never visited Canada so I expected more from Canada" (Female, Permanent Resident, age 32, 2 years in Canada). She further clarified that "… the

environment [roads, housing] actually looks maybe less developed. Even the health system is not satisfying" (Female, Permanent Resident, age 32, 2 years in Canada). Yemisi also believed that her preconceived notions of the level of development in Canada originated in the media:

> You have this mind set … the media portrays this mindset of coming to the western countries as being superior in terms of structures and things. And I live in Lagos in Nigeria so when I came to Manitoba, Winnipeg, I was expecting to see something wonderful but to my surprise I feel like the infrastructure wise, Lagos is way better than Winnipeg and that was a disappointment too for me. (Female, International Student, age 25, 1.5 years in Canada).

On the issue of access to food, Dayo explicitly described the availability of the same kinds of food that are usually consumed in Nigeria here in Canada, and that are easy to procure for people who have a preference in their dietary consumption. The participant stated that:

> I will say in terms of food. Food is something you also consider going to try new food, but once you are already used to your own kind of food back at home [in Nigeria], so I would say that's one of the experiences I have had. I have access to the kind of foods I love to eat back at home. So there is not so much difference between back at home and Canada (Dayo; male, International Student, age 32, 2.5 years in Canada).

The lack of familial networks in the new host country can negatively influence a new immigrant's settlement process. Interestingly, one participant who expressed her excitement about relocating to Canada viewed the lack of family as a double-edged sword. First, she stated:

> It was actually really exciting for me because I had never been away from home, I was day student [not a boarder] even in high school. So I was always home and like … just to be away, I wanted to see if I could be independent without being with my parents and still survive and do things. (Nike; female, International Student, age 20, 2.5 years in Canada).

However, independence from family can also be burdensome, as Nike also stated that the lack of familial network supports makes accomplishing tasks harder; one has to plan and execute

everything that is required by themselves (Female, International Student, age 20, 2.5 years in Canada).

In addition to the availability of social amenities and infrastructure, participants also mentioned that the existence of likeminded communities of individuals from the same source country with the same beliefs, lifestyle and ideas have contributed to a favourable settlement experience for them. One participant in particular stated that he is not really missing his home country, as there seems to be no difference in the people around him:

> …there is not so much difference you know from back [in Nigeria]. Going to a new environment thinking you won't see your people, and your, people from your country and all of those things. That's one of the things that comes to your mind. But in the last two years I have met people from like minds people that okay, also think the way I am thinking, people from the same environment and country. So that's why I will say is exciting. Not really missing much from home so. (Dayo; male, International Student, age 32, 2.5 years in Canada).

Furthermore, Dotun also reiterated the contribution of the community to a favourable settlement experience. This participant explained, with specific focus on his Christian religion, that the existence of a community of like-minded individuals around him helps him to grow and develop himself as an individual and spiritually, and reflects the broader freedom of religion in Canada unlike in some regions in Nigeria. This is explained in the following quote:

> Coming here [to Canada], I have also been able to find community of people of like minds … who are Christians like I am and who worship in exactly or similar ways that I am used to or that I understand. Because being a Christian is not something that is done in isolation, it is about being with other people of like minds and people who believe in what you believe and then you kind of help each other to grow and help sharpen [develop] each other. (Dotun; male, Permanent Resident, age 40, 3 years in Canada).

Participants also commonly reported that Canadians are quite friendly, welcoming and caring. Ijeoma (Female, International Student, age 20, 2 years in Canada) described her initial

journey to Canada where upon her arrival she experienced a severe weather shock and was very cold and fidgety; she was even considering returning to Nigeria from the airport, but the immigration officer got her a free jacket as she was not properly dressed for the weather. This same participant also mentioned a situation where she missed her flight due to a mix up in her itinerary, but she was taken care of and then seated in the business class on the next flight and also received a $500 gift card compensation for the inconvenience. Nike also explicitly stated: "People I have met so far. I would say of people I have met … most people I have spoken to, thank God, are really nice and they are actually friendly, they are not racist." (Female, International Student, age 20, 2.5 years in Canada).

This is not to say that there are no rude Canadians, however, as some participants also mentioned that they had experienced some unjust rudeness and discrimination in their interaction with some Canadians. Specifically, two participants directly stated that they have experienced discrimination both outside the health care system in Canada (within health-care discrimination will be discussed later in the findings section). In a non-health care setting, Nike perceived that a friend of hers was a victim of racial discrimination – specifically verbal abuse from a white woman on the bus. She believed this woman appeared to be angry at all the black people on the bus and took offense when her friend, who was standing, accidentally touched her while the bus in motion. This participant also cited another scenario where she believed she was a victim of racial discrimination – being judged by the colour of her skin:

> At my odd job in Calgary where I had to speak with some people, there was this white guy that opened his door, he saw me and he shut it back and he was like no I don't want to talk to you. I was like it's just me. But when my [white] colleague went there like to the door, he opened it and actually listened to what she was going to say and I was like really? Like are you kidding me? (Nike; female, International Student, age 20, 2.5 years in Canada).

This participant went on to state that experiencing discrimination made her feel sad because she is human and should not be judged by the colour of her skin as all human beings have their personal faults. She also stated that her response to discrimination is to move on from the situation and not focus on it: "But I just waved it off like it is okay."

In relation to the weather, participants mentioned the extremely cold weather in Canada. New immigrants to Canada, especially from countries like Nigeria (which typically only experiences weather that is either rainy or dry) can be unaware and unprepared to face Winnipeg's winter weather. As such, they enter the country without the proper attire and then they get cold, frustrated and sometimes ill in below freezing temperatures. A scenario of this was described by one participant who stated that:

> When I came to Canada for the first time, I didn't know about the weather. So I dressed inappropriately, (laughs) I was wearing a dress and a shoe with a very light jacket in the winter then I was so cold so fidgety. When I reached Montreal and it was so cold that I was crying (Ijeoma; female, International Student, age 20, 2 years in Canada).

Whereas this participant viewed the change in the weather in a negative light, another participant nonetheless expressed excitement about the change in the weather and the environment in the fall season:

> I kind of like the weather even though when I first came it was really, really cold, I kind of like fall. Let me specify I don't really like winter. But I kind of like the changes in the weather, I like the fact that there are like trees almost everywhere, the scenery is really good, I like the way everywhere looks. I just, I like the weather, I like the environment … (Yemisi; female, International Student, age 25, 1.5 years in Canada).

Lastly, on the issue of employment, participants expressed their difficulties in attaining good jobs that suit their professional qualifications. They also experienced under-employment due to

their lack of Canadian work experience, since their prior work experience in their home country is not considered in the job seeking process. This issue can be illustrated by this quote:

> The area that is most challenging area is just issue of work because as an immigrant you don't have the required Canadian experience. Despite the fact that you have been working your professional field for so many years before you arrived in Canada you still need to get the necessary Canadian experience. And that one has been a great … great challenge to so many immigrants including me (Funto; female, Permanent Resident, age 49, 3 years in Canada).

Dotun, who is a wage earner and was previously a banker in Nigeria also stated that:

> When I first came in it was … it took a while to get a job. The job I found it was a bit stressful and I didn't really like it eventually I was able to find something else which is not as stressful although it is not exactly what I want to do but I am working towards getting the kind of job I want (Male, Permanent Resident, age 40, 3 years in Canada).

Un/underemployment can have a significant impact on the overall settlement process of new immigrants as it determines whether or not they can adequately meet their daily needs for subsistence. Moreover, expectations are shaped by the belief of better lifestyle and chances in developed countries like Canada, but when the reality is the opposite, the eventual optimal settlement of these individuals comes into question. The belief in a better lifestyle and easily accessible opportunities in developed western countries like Canada has been noted in the preceding section on pre-migration expectations. The reality of the situation of underemployment and standard of living of new immigrants, however, is illustrated in a comment by one participant about resettlement expectations:

> Well when you leave your country and you expect that … well most times or in many instances it will not be like you come in and then you find the kind of job, the kind of accommodation you want as quickly as possible. I mean in order to be able to get back to probably the level you were when you were in your own country … (Dotun; Male, Permanent Resident, age 40, 3 years in Canada).

In summary, participants had a mix of positive and negative post-migration experiences which was to some extent influenced by media portrayal and shared assumptions about developed countries, and such cases were often characterized by unmet expectations. These experiences have contributed to their settlement and decision to remain in Canada as well as their overall impression of Canada as a country. Health in particular is a vital aspect of life and good health care can contribute to good quality of life; this consideration can also shape migration decisions. Thus, it is of importance to understand how participants view health, and this is examined in the next section.

4.3 Understanding Health: The Immigrant Perspective

As the aim of this research is to explore the experiences of newly arrived Nigerians in accessing and receiving health care services in Canada, there is a need to understand what health means to each participant. This section presents the views and beliefs of participants surrounding health in general or their personal health (they often drew on personal examples). The findings indicated that participants generally held more biomedical views of health, although some holistic beliefs were also expressed, and in addition, some participants expressed beliefs in the role of divinity or the supernatural in their overall health.

The biomedical view of health focuses on the absence of disease, and as a result more attention is given to symptoms associated with disease rather than the patient as a whole. Thus, the biomedical view is more functional than experiential in understanding (Segall & Fries, 2011). In contrast, a holistic view of health involves notions of a positive state of functioning and wellbeing surrounding the physical, social, psychological, environmental and spiritual component in relation to the totality of the individual. In other words, the complex interaction of biological/physical, psychological, social and spiritual components within an individual is

viewed as contributing to health (Segall & Fries, 2011). Data suggest that five participants held a more biomedical view of health, which was noted in their focus on physical and mental aspects of health. For example, one participant expressed a biomedical understanding of health as she explained it to simply involve the absence of illness or infirmity as can be noted in the following quote:

> To be healthy to me means every part of your body, you don't have any issue. You can go to bed and sleep and close your eyes, you wake up, you can eat well, you can move around. You are fit, physically fit and health wise too, you are fit mentally. When you are healthy, you are mentally and physically fit (Funto; female, Permanent Resident, age 49, 3 years in Canada).

A second participant similarly explained a view of health that also focuses on physical and mental fitness as aspects of health:

> There are so many ways to look at being healthy. Being healthy for me, I think it has to do with your physical being, your … it seems ambiguous. But now, for somebody that walks maybe five minutes, just taking a walk 5 minutes and after five minutes you have walked you are breathing heavily you are looking for where to rest on. You can classify that person as very unhealthy. Somebody that is unhealthy is if you go for checkup and the cholesterol level is very high but you still think can move around. You can still be classified as being unhealthy. But somebody that okay, work out regularly, someone that exercises the body and mind in terms of reading too it is part of exercise. You can be classified as being healthy… (Dayo; male, International Student, age 32, 2.5 years in Canada)

This participant also explained how one can achieve and remain in a healthy state by eating healthy and exercising the mind (e.g. through reading). Another participant expressed a broader view of health yet still focused on physical and mental aspects. First she emphasised physical health as reflected in lifestyle:

> Healthy is like being active, not just always sitting on your couch with Cheetos and watching TV, but being active, like maybe running for 30 minutes a day, like or swimming. Doing something. It's just staying fit. Not necessarily losing weight but

> staying fit. That's good health physically (Nike; female, International Student, age 20, 2.5 years in Canada).

Once probed about other aspects of health, however, Nike suggested mental aspects of health were connected to the physical: "the physical does contribute to the mental. Sometimes they work hand in hand most of the time anyway." She clarified this by noting that physical exercise has helped her with sleep and stress.

In a few cases, participants appeared to hold both biomedical and more holistic views of health simultaneously. For instance, one participant who is in a scientific field of study also expressed a biomedical view of health that involves the absence of disease. She stated that:

> I believe that to be healthy means you do not have any form of infirmity. For instance it is not necessarily until you have to be admitted in the hospital. I believe that if you have a head ache at that point in time you are not healthy. Because your body is trying to tell you something. The way the body conveys messages to us is by pain. If you are feeling discomfort, something is definitely wrong in your system. It might be temporary. Just like sneezing, the reason why you sneeze is because some particle or allergen got into your nostrils and need to be evicted so your body responds to that by sneezing (Yemisi; female, International Student, age 25, 1.5 years in Canada).

This participant goes on to define good health: "it means that everything with regards your body system, your vital signs and everything, everything is okay … There is no form of foreign objects in your system. And everything is working well in your system". Interestingly, however this same participant also expressed a somewhat holistic view of health when she emphasised "living right" and listening to your entire body. Furthermore another participant expressed a largely biomedical view of health but one which also was influenced by a more holistic view. This participant stated:

> For me to be healthy means that my mental, psychological, and physical state is balanced. In the sense that you are optimal. You wake up you don't have pains, you don't have psychological issues, you don't have emotional challenges, you don't have things you are dealing with that might not be physical and it's psychological. As well you don't have physical challenges that you need to probably see a doctor or things like. That's what I feel healthy means. Having a good quality of life (Bunmi; female, Permanent Resident, age 32, 2 years in Canada).

This participant explained her view of health as the absence of disease, but later on uses the term "quality of life" which has more holistic underpinnings.

Dotun, who had earlier shared his appreciation of community and who is also a Christian, expressed a holistic understanding of health as he opined that: "it is a state of physical, mental and social wellbeing. Health is not just about one's body, it also has to do with one's mind, intellect, relationship with people, for some people also maybe spiritual connections and ability to connect with people" (Male, Permanent Resident, age 40, 3 years in Canada). Although he emphasised physical function, he also emphasised social wellbeing (ability to relate to others). Amira, who is currently studying in a care related field, also reiterated this view on wellbeing and health. She stated: "when you say healthy, I think to be that your total wellbeing. So it's going to be your emotional, your physical, your spiritual, your psychological wellbeing. Just being in a good place. So it's the total wellbeing of the body and everything" (Female, International Student, age 22, 3 years in Canada).

Tobi, who is a researcher, also painted a scenario that also embodies the holistic view of health in relation to balance in the following statement:

> There are times you might be depressed or you might be mentally stressed with research and you forget to do some stuffs. Like I have seen people that have been seriously engrossed in their research and they don't even have time to pay attention to their other lives. In that area I will say maybe, you know, when you are healthy you find time to do everything no matter what (Tobi; male, International Student, age 32, middle-upper class 2.5 years in Canada).

Another participant made reference to her own health experiences in advocating for a more balanced approach to life beyond the physical:

> To be healthy to me means to be healthy emotionally, physically, and you know psychologically as well. Because I used to suffer from depression and I was unhealthy. Sometimes I still struggle with that. [Good] Health means being healthy all round. In every area of your life. Even though it is not physical (Ijeoma; female, International Student, age 20, 2 years in Canada).

Lastly, four participants also expressed beliefs that account for the role of divinity in their overall health status. One participant stated:

> It has to do with one realizing that one is not here by accident. God made us to relate with him. This environment is one in which there is freedom to practice your religion or to put to practice whatever your religious convictions are without any inhibition or any disturbance (Dotun; male, Permanent Resident, age 40, 3 years in Canada).

Other participants made similar statements but focused more on a belief in divine roles in shaping health outcomes. For instance, Nike stated: "Also God is God. He created me and if I have any disease, He is able to take it away. That is faith. No physician can stand next to him" (Female, International Student, age 20, 2.5 years in Canada). Other participants, in describing their health care experiences, made similar statements that emphasised the role of divinity in keeping them alive and healthy, which includes the following two quotes: "…I am a Christian, God has kept me [saved/protected me/kept me alive] …" (Bunmi; female, Permanent Resident, age 32, 2 years in Canada); and "I was diagnosed of malaria fever and they kept on treating me for malaria fever but I realised in the long run that it was jaundice. It was God that saved me" (Tobi; male, International Student, age 32, middle-upper class 2.5 years in Canada).

The interview data reveals that participants can simultaneously hold a belief in either or both the divine and the personal responsibility in ensuring good health (as shown by Dotun and

Nike). In relation to personal responsibility for wellbeing, participants expressed views such as being active/keeping fit, reducing stress, eating right and good rest/sleep. In relation to the divine role in health, participants expressed views of divine supremacy in keeping them alive and in good health. Overall they expressed views that acknowledge the importance of good health to one's overall wellbeing and this is the backdrop for understanding the health care experiences of participants, which will be discussed in the next chapter.

CHAPTER FIVE

Findings Part 2

5.1 Perceptions of Health Care Services in Nigeria

This section aims to explore the interview data on participants' experiences in accessing and receiving health care services in Nigeria, and their evaluations of these experiences. As with any research on experiences, there are always positive and negative experiences – life is complex and nuanced, as are interpretations. The data from this research reveals that participants had both negative and positive experiences with the health care system and personnel in Nigeria and this often shaped their view of the quality of health care services in Canada as well. Thus, although this chapter starts by exploring perceptions of health care in Nigeria, understanding these interpretations helps us understand evaluations of Canadian health care experiences.

In relation to participants' experiences with health care in Nigeria, the research data reveals the following themes; easy access, cost, speed of service delivery, convenience, fairness, attitude and demeanour of health care practitioners, trust, and quality of care. Each theme is explored below with positive and negative experiences being linked and contrasted against each other, with the aim of contextualising the findings and creating deeper understanding of the complexities surrounding each theme.

5.1.1 Ease of Access

When asked about their experiences with the Nigerian health care system, eight of the nine study participants characterized access to health care services in Nigeria as fairly easy, while qualifying that this hinges on ability to pay. For instance, Bunmi who has a history of asthma noted that access to care is quite easy and free of delay. She stated that:

> The weather in Nigeria is not really favourable to asthmatic patients when it get cold. It doesn't get this cold, it's dusty you have allergies that you react to. But once I get into the emergency, I get care immediately. Asthma can just take your life immediately. So I get care (Bunmi; female, Permanent Resident, age 32, 2 years in Canada).

Dotun also stated that: "Accessing health care in Nigeria is kind of easy if you have the money" (Male, Permanent Resident, age 40, 3 years in Canada). Ijeoma, who is a university student and identifies as being off the middle-upper class in Nigeria, also similarly stated:

> I don't want to say I was born with a silver spoon, but me being from a high class in Nigeria, I was able to access the best of health care in Nigeria. So that meant that anytime I am sick it is just a phone call to the family doctor. He would probably come to the house or we go (Female, International Student, age 20, 2 years in Canada).

Also a fourth participant mentioned: "I have never really had problems and I have been to the hospital a lot in Nigeria. I have never really had problems with the hospital basically. I myself have not so I can only speak for myself" (Yemisi; female, International Student, age 25, 1.5 years in Canada).

In relation to social class as a key determining factor, Tobi stated: "…if you are in the upper class then accessing the health care in Nigeria would be very easy but it's not cheap" (Male, International Student, age 32, middle-upper class 2.5 years in Canada). Perceptions of cost are further explored in the following theme.

5.1.2 Cost of Health Care

All participants described themselves as belonging to the middle and mid-upper class in Nigeria but despite this, they were quite aware of the inequities in access due to cost even when it did not personally affect them. Most participants mentioned in various ways that quality health care services in Nigeria are quite expensive and often beyond the means or abilities of the low

income earning members of the society who often have seek health care through alternative means. In order to illustrate this, one participant stated that:

> But if you really want to enjoy the health care in Nigeria then you must be … if you are in the upper class then accessing the health care in Nigeria would be very easy but it's not cheap … So I would say it depends on the class you belong to in my country. If you are in the upper class, then health care system, you would not have anything to say about it. Because you have what you want, the same treatment and everything you might get from abroad, you can get it in Nigeria. But it depends on your financial stability (Tobi; male, International Student, age 32, middle-upper class 2.5 years in Canada).

Similarly, another participant reiterated this point and noted that health care should be affordable as he stated that:

> …health care system in Nigeria is good but it's expensive. If you want to get good health care because we have international standard hospitals in Nigeria that have equipment's and all of those things. But health care system which is supposed to be like affordable for all is expensive (Dayo; male, International Student, age 32, 2.5 years in Canada).

Another participant also noted the cost difference between the private and public hospitals, as she argues that private hospitals are the choice for faster service but they are quite expensive and if one cannot afford the cost, then the public hospital is a slower but cheaper alternative (Funto; female, Permanent Resident, age 49, 3 years in Canada).

Thus, while participants might argue that access to health care is easier in Nigeria they also acknowledge that this might not be the case for all groups in Nigeria. Likewise, those who can pay for private services also receive faster service delivery, as the next theme explores.

5.1.3 Speed of Service Delivery

Funto (Female, Permanent Resident, age 49, 3 years in Canada) painted a scenario from her personal experience where she faced delays, cancellations and long wait times in the process of accessing specialist care in Nigeria. This participant mentioned that she had to wait for hours to see a specialist physician and at the point when her surgery was scheduled, she also had to

wait for hours for her pre-surgery test; she was unable to receive the test within the required time frame and this resulted in the cancellation of the surgery. Upon the rescheduling of the surgery it had to be cancelled again due to it being a statutory holiday.

Only one participant painted a scenario of speedy service delivery in a public hospital in Nigeria, where she received immediate care:

> I came in with this excruciating pain. I couldn't stand, I had to get on a wheel chair by the time I got to the hospital it was really bad. And it was acute so it was an emergency. So I was scheduled for a surgery that day and I had the surgery. I had my appendix taken out it was retrocecal. And I had peritonitis so I was cleaned up as well. It felt better I've never had the pain again (Bunmi; female, Permanent Resident, age 32, 2 years in Canada).

Overall, however, participants noted that receipt of necessary care is somewhat faster in Nigeria than in Canada, and two participants attributed this speed to privately run hospitals where access is based on a fee for service system. Dotun believed that short in-office wait times in Nigeria were linked to hospitals' for profit status (Male, Permanent Resident, age 40, 3 years in Canada) and their smaller patient loads. Similarly, Yemisi also attributed faster service delivery to privatized payment: "because you are paying, you are getting the value for your money" (Female, International Student, age 25, 1.5 years in Canada).

Similarly, these two participants believed that service delivery in public hospitals can involve delays and cancellations, in part linked to lack of a formalized appointment system. This aspect will be discussed further below, where it was characterized in a more positive light by some participants.

5.1.4 Convenience

In relation to accessing health care services in Nigeria, two participants made specific mention of not requiring an appointment for medical care visits; this was an aspect of

convenience that they appreciated. That is, appointments were not needed when an individual has a reason to see a doctor. Dotun stated with respect to private hospitals in Nigeria: "You don't have to book an appointment, you don't have to wait for a period of time to be able to get an appointment space, all you have to do is when you are ill or you have a need to see the doctor, you just walk in and then you are attended to" (Male, Permanent Resident, age 40, 3 years in Canada). Yemisi also reiterates this opinion but extends it to include public hospitals in Nigeria. This participant stated that:

> …let's say for instance, I don't need to book an appointment … to go to a public hospital. I can go there and want to see the doctor but then I would have to wait for … it depends on the number of people that are waiting to see the doctor. And the good thing about the public sector is that they have several doctors. So even though there is so many people they think is it seems considerably fast because they have several doctors but you might still need to wait for a while. But in the private hospital you are paying and because you are paying, you are getting the value for your money. Like if I go to a private hospital I am able to see the doctor. I might not even wait five minutes I am going to see the doctor.

Some participants mentioned that their physicians were readily available for consultation at any time; they had easy access to them and could get in contact and see them without any delay and at their convenience. Two participants made mention of this. For instance:

> … I started seeing him [the doctor in neurology] and from time to time we book appointment or he just says okay see me in two weeks. Or If I have a need to see him I will just call him "hey doctor I want to see you" and he will say okay. Usually the only time I am available to do things like that is the weekends and he will say that fine by me. You can come on the weekend at any time you choose. (Dotun; male, Permanent Resident, age 40, 3 years in Canada).

Dotun further emphasised this easier access to physicians in Nigeria by stating that: "…the professor of neurology I was seeing in Nigeria, I just needed a referral and then you could see him probably the next week if he is available. You could see any specialist with in a short time in a week or two weeks and that is even dependent on the availability of the patient." Ijeoma, who

identifies as being of the mid-upper, class stated: “anytime I am sick it is just a phone call to the family doctor. He would probably come to the house or we go … but most times he comes to the house because I hate going to the hospital” (Female, International Student, age 20, 2 years in Canada).

However, as was suggested by one participant earlier, a lack of appointment system can also function as a barrier to access when not properly monitored, as this can lead to unfairness in the health care system; issues of fairness are further explored below.

5.1.5 Fairness

Two participants indicated the existence of corruption and unfairness in the health care services system in relation to access to specialist physicians. Bunmi (Female, Permanent Resident, age 49, 3 years in Canada) described her experience with gaining access to a specialist physician in a public hospital as ridden with inequality; she had to arrive at the hospital two hours before the physicians attend to patients in order to be able to get a good time slot. The unfairness was in the fact that the hospital auxiliary staff pick out numbers and early time slots for their friends and family members, who can come in at any time before 9am, when the physicians start attending to people. As a result, even people that arrive early end up getting a later time slot/appointment.

A second participant sheds light on the issue of corruption in the health care system in relation to resource allocation and access to prescription medication in the following quote:

> It is not as if the health care system does not have the resources too or it’s not as if we do not have the allocation the health care system but because of selfish interests … the resources are being managed and being used for selfish purposes. There are some drugs that cannot be accessed by the private [hospitals] but the government can get it and when the government officials’ start selling all these things to private clinics it becomes crazy, and when you that don’t have the money to visit the private clinics then you don’t have access to the drug. (Tobi; male, International Student, age 32, middle-upper class 2.5 years in Canada).

Thus, as Nigeria does not actively practice formalized appointment systems, this leads to situations where only a few – and sometimes undeserving – individuals gain access to health care services promptly in public hospitals, sometimes at the expense of others who might need urgent care. Despite this situation, a number of participants describe physicians in Nigeria in favourable terms based on their interactions with them; this topic is the subject of the next theme.

5.1.6 Attitude and Demeanour of Health Care Practitioners

About five participants described health care providers in Nigeria are quite caring overall, using words like "concerned," "friendly," "nice," and so on to describe their relationship or interaction with these practitioners. Dotun described meeting a specialist physician: "there is this particular doctor, he is a professor of neurology, [and] he has his hospital somewhere in [States Place] Lagos, Nigeria. When I had a need to see him, he was eager to meet me and discuss the issues and all of that" (Male, Permanent Resident, age 40, 3 years in Canada). Another student participant, who identifies as being of the mid-upper class, described Nigerian people overall as caring and this includes health care providers:

> Even if they don't know you, Nigeria is a place where everybody cares I would say. When you are sick and you go to a hospital everybody cares about you … the nurses are make sure you don't take cold water … make sure you take this medicine, the doctor is always looking after you, always wants to know what is wrong with you and how you are doing. He always interacts with you, always wants to get in a conversation with you. He is concerned. Yeah I love Nigerian health care. (Ijeoma, female, International Student, age 20, 2 years in Canada).

Nike also described her interaction with her family doctor: "He knew what was wrong with me. He didn't … he wasn't rude and he wasn't super nice. He was just gentle" (Female, International Student, age 20, 2.5 years in Canada). She also went on to describe her interaction with the nurses in a small private hospital in favourable terms. She stated that:

> They took their time to hear what you had to say. They were patient enough. They weren't just like … 'I already know what is wrong with you from looking at you. Please just move on'. Like they answered your questions, if you are like huh? What are you … layman terms please? They would be like okay, let me talk you back through it. If you don't understand your medication, they talk to you about it.

Furthermore, three participants indicated that physicians show their concern and care for their patients through communication that is open, easy, informal and informative. They mentioned that their physicians were willing to listen and answer their questions at any time and also had open discussions with them about treatment plans. The first participant described his experience with a particular doctor, specifically open discussions about treatments, in the following quote:

> There is another doctor whose clinic was close to where I lived, it's a private clinic as well, [name of doctor] we were seeing … my wife and I were seeing him for a while. And each time he was always like meeting a family friend and then talking about the issues and then seeing the options that are available and all that for treatment and all that. (Dotun; Male, Permanent Resident, age 40, 3 years in Canada).

Yemisi also painted a scenario where she was able, from a doctor in a private hospital, to get answers to questions about a past surgery after a number of years; her doctor was patient with her and addressed all her concerns (Female, International Student, age 25, 1.5 years in Canada). She also made note of her experience with a dentist in Nigeria who was very forthcoming with information on procedures and inquiries, took time with her to explain procedures and suggest additional options. She added: "even though I did not come for that procedure or pay for that she took out the time to do that for me and I feel that as a medical practitioner or a physician it is your duty to the patient to do what is right for the patient."

In contrast, however, three participants also described health care providers in Nigeria, specifically nurses, in negative terms as "rude," "mean," and uncompassionate in their interactions with patients and their families. As one participant stated:

> One thing I see as lacking in practitioner in Nigeria is compassion for the patients. Even though they are nurses, they are providers but they have little or no compassion for the patients. I have seen people who have stayed with patients in the hospital that die and then they just drag them anyhow and even jesting about it (Dayo; Male, International Student, age 32, 2.5 years in Canada).

Nike who is a science student and of the upper class in Nigeria, also explained that her interaction with nurses at a hospital led her to change family doctors and hospital: "Some of the nurses were kind of rude *(laughs)* they don't really look at your face or anything. They are just like please get out of here quickly. I changed hospitals because of that" (Female, International Student, age 20, 2.5 years in Canada). Yemisi also similarly mentioned: "In Nigeria the nurses are really annoying but I have never really had too many bad experiences. But I know nurses in Nigeria are kind of mean especially if they have to give you injections and things like that. But here [in Canada] they are nice and courteous" (Female, International Student, age 25, 1.5 years in Canada). Amira also reiterated this view as she stated: "In Nigeria, if you go to the hospital all the nurses are not smiling, they are strict and very gloomy, like causing them bad luck or you are disturbing them. So you don't feel comfortable talking to them. I'm not saying always smile as you can just have a positive energy when attending to people" (Female, International Student, age 22, 3 years in Canada).

Thus, while most participants described their interactions with their Nigerian physicians in favourable terms, only one participant described her interaction with nurses in favourable terms. Overall, Nigerian nurses were described in less favourable terms (e.g., rudeness and so on), and in one case this caused a participant to change hospitals. Participants view a good doctor

as one who is willing to listen and communicate, who demonstrates concern for patients and provides solutions to problems. As a result good physicians are able to secure their patients' trust in their abilities, as explored below.

5.1.7 Trust

Participants emphasised their trust in the abilities of their Nigerian physicians and/or the Nigerian health care system more generally, in a number of ways in their talk, such as by making mention of their lack of fear in the treatment or their surgical procedure. One participant specifically mentioned his physician's qualifications and certification, as he stated that: "…he is a great guy, he is a professor of neurology, he is well certified, [and] I see him attending conferences all over the world" (Dotun; male, Permanent Resident, age 40, 3 years in Canada). Another participant illustrated her trust in her physician by painting a picture of her lack of fear during her awake surgery in the following quote:

> First of all, I wasn't really thinking much of it, I wasn't even scared or anything probably because I was young and stupid I don't know. But I didn't think of it as a big deal and stuff. I wasn't even a sleep for the surgery. I was awake. Because it wasn't like a serious procedure (Yemisi; female, International Student, age 25, 1.5 years in Canada).

Bunmi, who is a mother of the middle class displayed her trust in her doctor's ability and believes that they had her wellbeing at heart as she noted: "I had peritonitis so I was cleaned up as well. It felt better I've never had the pain again whether that wasn't the cause or not but the pain went it has never reoccurred. So I think far and large the doctors that saw me actually tried to rule out everything" (Female, Permanent Resident, age 32, 2 years in Canada).

In contrast, two participants expressed their distrust in Nigerian physicians due to their personal experiences with problematic surgical procedures. First, Dayo who was living with the result of a failed surgery that affected the sound of his voice, noted how this shaped his future

health care utilization in Nigeria: “It has affected a very bad impression for me. You know sometimes when you feel issue you don’t even want to go to hospital because they could even complicate the matter for you” (Dayo; male, International Student, age 32, 2.5 years in Canada). Similarly, Funto who is of the middle class and who had experienced a great deal of problems in accessing specialist physician services for a nose block issue, expressed this fear by opting out of another additional minor surgery after the initial surgery failed to resolve her condition. Instead she opted for self-medication as a means to manage her condition despite the risks. She stated: “on my own I would buy a lot of drugs. To the extent that I even order drugs from the US” (Female, Permanent Resident, age 49, 3 years in Canada).

5.1.8 Quality of Care

Two participants mentioned that their surgical procedures in Nigeria were free of post-surgery complications. Yemisi in particular mentioned that she went home immediately after her lumpectomy operation in the following quote: “I went home like that same night, immediately after. I went home immediately after and I was awake for the surgery. I don’t think that was a bad experience because I was able to go home that same day and few weeks later I was fine.” (Female, International Student, age 25, 1.5 years in Canada). Bunmi also explained that she had three surgeries done in Nigeria and they were all complication free and with minimal scarring. As such, these participants expressed their trust in their doctors’ abilities and they generally described health care in Nigeria in positive terms.

However, despite some of the positive aspects noted above, overall health care service delivery in Nigeria is seen as substandard, as noted by three participants most especially in comparison to Canadian health care services delivery. Dayo stated: “I think health care in Nigeria is below average” (male, International Student, age 32, 2.5 years in Canada). Tobi, a

student researcher, described a number of reasons for substandard care in the Nigerian health care system including: "… in a situation where you will be referred to another private hospital for operation that means the government hospitals cannot just perform the operation" (Male, International Student, age 32, middle-upper class 2.5 years in Canada). Funto also emphasized the substandard care in public hospitals in Nigeria, adding that:

> Even the treatment itself may not be up to the standard or may not be able to cure the ailment the way you want it. Because some of the drugs that are in the market are substandard and you discover that you keep on using them and there is no result. So you kept on going in and out of the hospital. (Female, Permanent Resident, age 49, 3 years in Canada).

Substandard care can result worsened conditions caused by delayed treatment as patients refuse to seek care until such situations become unmanageable due to their fear of misdiagnosis or medical error. Two participants cited instances of medical error by virtue of misdiagnosis and post-surgery complications. In relation to misdiagnosis, Tobi described a scenario from his personal experience where he almost lost his life due to the misdiagnosis of his illness which was not identified until his illness was at a critical stage. He stated: "so for someone to graduate from medical college and being given a certificate of a Medical doctor and can't even distinguish between a fever or typhoid or malaria and jaundice…" (Male, International Student, age 32, middle-upper class 2.5 years in Canada). He also described another instance where his friend was also misdiagnosed in Nigeria for appendicitis but received the correct diagnosis and treatment in Canada for kidney stone.

Similarly, Dayo described an instance of misdiagnosis at a clinic that he used to visit during school: "everybody is diagnosed for the same thing. Everyone is malaria, everybody is malaria, just give him malaria drugs. People have died because of wrong diagnosis" (Male,

International Student, age 32, 2.5 years in Canada). He proceeded to cite a particularly important post-surgery complication which affected his voice:

> I can't forget my experience with health care in Nigeria because I was taken to the hospital when I was barely one year old and I was operated upon because I had breathing problem and I came back with a worse ailment after the surgery. I think if you would use my experience I think nobody will attend hospitals again in Nigeria. For me, there is poor health care delivery system because going to a doctor that is supposedly qualified and at the end of the day you get a wrong diagnosis …

Relatedly, two participants expressed the view that physicians or medical practitioners in Nigeria are not properly trained or qualified. Tobi stated that:

> You cannot compare the training received here [in Canada] and the training over there [in Nigeria]. I know of a school, my school in Nigeria, after your first year, year one you go to medical school right? Which here you need to finish a biological led degree Bachelors before you go to medical college. You know the training is rigorous I think here. It's rigorous. And the faculty members here I think they are kind of exposed because of their research experience so they tend to teach you." (Male, International Student, age 32, middle-upper class 2.5 years in Canada).

Overall, participants had a mix of positive and negative experiences with health care providers in Nigeria and this often influenced their decision on how, when and whether to seek care or to change hospitals or health care providers. While some participants indicated that access to care was quite easy for them, other participants indicated the opposite, and cited the poor quality of services as well as certifications and training of physicians which in their experience led to misdiagnosis and medical error. Most participants were concerned about their interactions with health care providers, as positive interactions aided patients' satisfaction while negative interactions led to change in physician/ hospital and delay in seeking care.

5.2 Perceptions of Health Care Services in Canada

The research interview data suggests that participants had both positive and negative impressions of the Canadian health care system and that these interpretations were informed by both their personal experiences and the experiences of friends/ family around them. The data also illustrates how negative experiences shape impressions of the health care service delivery system as well as decisions about whether or not to seek health care in the future, and strategies used when they do seek health care.

The interview data reveals the following themes which were related to either/both positive and negative health care experiences, as indicated by research participants: easy access, cost, speed of access and service delivery, attitude and demeanour of health care practitioners, trust, and availability of resources/infrastructure. Further, in this section themes will be linked and contrasted with each other to provide further depth of analysis.

It should also be noted that for some participants, attempts to access health care services in Canada were characterised by disappointment and unmet expectations especially in relation to their preconceived ideas of the health care system in Canada. For example, a participant stated that:

> Well as a whole, it's not as fantastic as it appears to be for someone who has not lived in Canada. When you are outside in Africa, you always hear stories about health care being like very super in developed world, in North America. That gives the impression that is there is a need (snaps fingers) you can access health care on the flip of the finger. But it is not exactly like that. There is a lot of protocol, procedures, delays, things like that. So it's not exactly or glamorous as it is made to look if you are not living within Canada." (Dotun; Male, Permanent Resident, age 40, 3 years in Canada).

Dotun's disappointment is linked to issues in accessing required services, which is explored further below.

5.2.1 Ease of Access

On the issue of access to health care, Tobi expressed his view borne from his personal experience that gaining access to health care in Canada is quite easy and without complicated procedures, especially in obtaining physician appointments. He was quite adamant that there is nothing out of the ordinary about accessing health care in Canada and moreover, that as a result it is not even memorable, specifically because it is not marred by negative experiences or interactions:

> …when you say experience, most experience you try to keep is when it becomes very difficult and you say 'I would never forget this experience'. But when it's very easy and you can access it, you just do it normally. I can stand up here and go to the medical centre and they will attend to me so far it's still in their working period. I have hospital beside my house I would just walk in if I have any issue, the only thing I need to follow is the queue if people are on ground, then I need to follow the normal protocol. And if it requires me to see a specialist I will be given appointments and they will answer me in no time. I have been to … the hospital and I was attended to very fast and I really enjoyed it that is the fact. (Tobi; male, International Student, age 32, middle-upper class 2.5 years in Canada).

As Tobi later explained, positive experiences are easy to overlook whereas negative experiences tend to "stick" because you simply "cannot forget this experience."

Dayo echoes a view of easy access to health care in Canada and even explained how he accesses health care: "generally for me I would say it has been quite easy. You just Google and you can search for hospitals or clinics in your immediate environment, you can give them a call and book an appointment, it's easy …" (Male, International Student, age 32, 2.5 years in Canada). He also stated: "I have not had any problem getting any health care services in my little stay in Canada."

Furthermore, regarding appointments, Nike, a science student, expressed that same-day appointments for some GP's and Walk-in Clinics are easy to schedule with little in-office wait

time: “I went to the clinic and within an hour I saw the doctor” (Female, International Student, age 20, 2.5 years in Canada). She described her interaction with the reception staff when she booked the appointment:

> I walked in and I was like I need to see a doctor or something. She was like what’s wrong with you? I told I am feeling nauseated. She said fill out this form. I filled it out. She was like okay can you come back in an hour she would be able to see you then and I was like okay no problem then I left. I came back after an hour I sat down, someone called my name and I went into her room.

Further, two participants believed that referrals for specialists in particular health conditions can be easily obtained through one’s family doctor. Funto described a personal experience where she had been living with and managing blocked nostrils. Upon seeing her family doctor in Canada she received a referral for a nose specialist and was scheduled for an appointment (Female, Permanent Resident, age 49, 3 years in Canada). Ijeoma mentioned that her family doctor was an active link between her as a patient and the specialists for her condition, as she saw three specialist as arranged by her GP before her eventual hospitalization. She explained this in the following quote:

> I was really sick I told you last year and then I went to the school clinic and then she [the family doctor] was the one that directed me to this hospital. She was the one that contacted the people because I went to three different hospitals because I saw different specialists. Then I was admitted in one of the hospitals (Ijeoma; female, International Student, age 20, 2 years in Canada).

As with any human experience, participants hold diverging views on the issue of access to health care, and some participants offered both positive reflections of some aspects of systems, and negative reflections on other aspects. While comments above focused on the ease in accessing health care services, other comments focused on more negative impressions related to

delays and long wait times in the process of seeking health care services. These will be discussed below.

5.2.2 Speed of Access and Service Delivery

Three participants opined that health care service delivery in Canada is slower than expected and that this is unacceptable in the long run especially when a quick procedure is required and the life of the patient is on the line. Yemisi made an explicit comparison between the Nigerian and Canadian health care delivery systems; she noted that the Nigerian system is faster and more effective, whereas: "…here [in Canada] you would still be nursing the conditions for a long period of time just because you haven't had the test done and the physician cannot deduce anything if you haven't done tests. So I am not really crazy about the health care system here" (Female, International Student, age 25, 1.5 years in Canada).

Nike mentioned the fact that a friend of hers was currently waiting for a surgical procedure for a torn ACL muscle to be scheduled: "he needs to get that surgery done fast quickly because if they leave it torn, he might never be able to like use his leg properly. They need to do things on time" (Female, International Student, age 20, 2.5 years in Canada).

A long wait time was reported by other of participants in various areas such as specialist appointments, emergency room visits, in-office doctor visits (Family Doctor), and diagnostic tests. First, in relation to specialist appointments, which normally require three months wait, Dotun noted: "the wait time for seeing specialist is appalling" (Male, Permanent Resident, age 40, 3 years in Canada).

Second, in relation to emergency room waits, four participants explained their challenges in accessing health care through the emergency rooms, which requires a lot of patience. This is illustrated in the following quote:

> There was a time I went to [hospital] just for emergency check-up. I was having issues with my eye and I went. And I stayed in that hospital for almost six hours before I was attended to … If you are on emergency, you are not sure of the number of hours you will stay before you get treatment (Funto; female, Permanent Resident, age 49, 3 years in Canada).

Nike also described going to the emergency department for what she believed was an emergency need, and she had a final examination in school scheduled for the following morning. She explained: "…The nurse came up to me and asked like a few questions. Then she was gone I didn't see her. Then we were waiting for hours and hours" (Female, International Student, age 20, 2.5 years in Canada). When she did see someone it was a nurse practitioner, not a doctor. Amira echoed this view as she explained that when she visited the hospital for treatment for a head ache, she had to wait for about eight (8) hours to see a doctor: "and when I saw the doctor, I wouldn't say it was worth a wait, because having a doctor that really cares about how you feel makes the difference" (Female, International Student, age 22, 3 years in Canada). Another participant reiterates this view and also opined that the system does not consider the patients' conditions in the emergency room as real emergencies:

> When you have an actual emergency, I don't think you get to access it right. Because I think right at the back of the systems mind, let me just use that word because it is not just one doctor called that is the system but the system at large, they think there is no emergency. Like they think you get into the emergency, you are stable, you will be fine, and you wouldn't die. But it is not the same because you come to the emergency. If you have to get to the emergency, it is an emergency (Bunmi; female, Permanent Resident, age 32, 2 years in Canada).

Third, in-office wait time refers to the length of time waiting in a walk-in clinic/GP's office for an appointment, Dotun who is a wage earner and identifies as being middle class, shared his views on this issue:

> …even when you book appointment maybe for 10 o'clock and you get to the hospital like 9:45. You probably, most case you will not be able to see that doctor till like 10:30 most

> times. They are usually like over booked. There is never a time I go in for an appointment and I get to see the doctor on the dot … I mean you know at the exact time I am supposed to … at the time the appointment is for. Usually it's like 15 to 20 minutes (Dotun; male, Permanent Resident, age 40, 3 years in Canada).

He proceeded to describe the wait time for treatment in Canada as unacceptable especially in comparison to a less developed country like Nigeria where wait time is significantly shorter: "Considering that even in places that are … other places that are not as developed like we want to, just imagine getting treatment doesn't take as much time …the time to see the doctor is unacceptable."

Fourth, in terms of diagnostic tests two participants mentioned that the wait time is unacceptably long, especially since delay at this level lengthens the suffering and worry of the patient. For instance as one patient described:

> I had a really big issue last year and then I had to from doctor to doctor to doctor. And then let's say I go okay I want to book an appointment, my appointment was like three months after. So I was like this is something easy. I think this calls for an appointment in like a week why put me in three months? Do you understand? And then it was just keeping me anticipating you know oh what are they going to find in the result or what am I going to hear from the doctor? Just stuff like that. That time is too long (Ijeoma, female, International Student, age 20, 2 years in Canada).

Yemisi, who is a science student, also corroborated this point with her experiences. When she arrived in Canada she noticed a bump on her abdomen, so she went to a physician to seek diagnosis:

> I found it ridiculous that in order to get an ultrasound done to verify what the bump was or what was really happening, my ultrasound was scheduled eight months after and speaking as a scientist, I believe that there are so many things that can go wrong in eight months especially when we are talking about a growth. Even if something might be benign, it only takes a few mutations to happen for it to grow to be cancerous. I think it is ridiculous to have to wait so long to actually find out what's wrong with you (Female, International Student, age 25, 1.5 years in Canada).

She also added that: “I have had dealings with other people too who have said people have died waiting to have their tests done and I think that is really ridiculous.” Dotun also shared a similar view as he stated that a three month or more wait time for tests is “a lot of time for things to get worse if it’s really an issue that needs to be attended to as quickly as possible” (Male, Permanent Resident, age 40, 3 years in Canada). In relation to long wait time, Ijeoma (a female student, aged 20yrs and of the Mid-Upper class) also stated that she experienced a lot of worries about her condition when waiting to hear from the doctor.

Despite these negative experiences, other participant comments’ reflected more positive experiences with health care service delivery, including cost and interaction with health care providers. As such, the following sections will present each of these themes using quotes and phrases from participants’ interviews.

5.2.3 Cost of Health Care

In relation to the *Canadian Health Act* and the Universal Health Insurance coverage, some participants expressed their appreciation for this in contrast to the user-fee based Nigerian health care system, as it gives them more service options. Nike expressed her appreciation for the publicly funded health care system in Canada as she explained: “I like the fact that it is free. Now that’s a really good thing. Health care should not be joked with.” (Female, International Student, age 20, 2.5 years in Canada). Similarly, Yemisi held this view even as she acknowledged that the system is not perfect: “It’s not perfect …don’t get me wrong I love the fact that we have free health care system or free health care” (Female, International Student, age 20, 2 years in Canada).

Participants recognised that the publicly funded health care system despite its imperfections is very important, as good health care is vital. Interactions with health care

providers are also noteworthy and the next section reports on participants' impressions of the Canadian health care service providers in particular, which is borne from their interactions with them at various levels of accessing and receiving health care services.

5.2.4 Attitude and Demeanor of Health Care Practitioners

Seven participants described their overall experience of interactions with health care professionals and personnel in favourable terms using words like: "friendly", "caring", "professional", "efficient", "respectful", "civil", "courtesy", and so on. For instance, Funto described her experience with caring nurses on the day of her surgery and added: "overall, the service is been good and excellent and the health care workers too they are very friendly and efficient" (Female, Permanent Resident, age 49, 3 years in Canada). Funto further described a scenario to illustrate the caring and reassuring manner of the health care personnel during her surgery:

> …when you are going for a surgery, you will be afraid, so many things will be going wrong in your head. But here, they will assure you that you do not have anything to fear, they are always with you, and nothing will go wrong. Even the doctor that will do it will come and tell you this is what I will do, I will do this, and I will do this. There is no problem. I have some other people with me that will attend to you. So with that, your mind will be settled.

Similarly, Ijeoma reiterated the niceness of nurses, as she added: "they always smiled and they always you know like to get in conversations with you. They always you know try to make you feel like you are worth it." (Female, International Student, age 20, 2 years in Canada).

Furthermore, Dotun who is of the middle class and currently a wage earner, also explicitly noted that health care personnel in Canada are more courteous or respectful, especially in handling patients' information. This participant noted that: "There is a lot of courtesy. People treat people with respect especially the front desk people well compared to Nigeria. There is

courtesy, people are treated with respect and information is treated in confidence. That's not exactly the situation in Nigeria" (Male, Permanent Resident, age 40, 3 years in Canada). It is noteworthy that this impression of interactional respect is likely more attributable to existing Canadian legislation related to the handling of patient health information (e.g., a system characteristic).

Further, four participants described their communication with health care providers and personnel in Canada as characterized by open discussions and reassurance when required. One participant who is a student researcher expressed his favourable evaluation of his interaction with his family doctor, as he stated that:

> I was gisting [conversing informally] with the doctor on a very good platform. It was this nice Indian doctor, he was gisting with me and we were talking at length and it was fun though. It was fun. It wasn't just, aside the fact that it was professional because I went there for medical checkup …we talked personal issues and other advice and everything. It was okay (Tobi; male, International Student, age 32, middle-upper class 2.5 years in Canada).

Dayo similarly stated that: "the doctor attended to me very well. I had a very nice time. Even after the whole medical we spoke about other things not medical inclined" (Male, International Student, age 32, 2.5 years in Canada). Another participant corroborated this view on effective communication between physicians and their patients but with more emphasis on the listening aspect of communication. She stated:

> When I take my kids to … my kids' pediatrician, she is fantastic. When it comes to the pediatrician, she knows her job and she is fantastic. The doctors, they communicate, they explain to you the process, they talk to you, they listen …they listen, they tell you what it is. (Bunmi; female, Permanent Resident, age 32, 2 years in Canada).

Funto who is a caregiver and a volunteer indicated the importance of communication between health care personnel and patients specifically in providing pre-surgery reassurance: "they will

tell me that I will stay by your side when the surgery is going on. Then they called the doctor and the doctor came to see me before the anaesthesia was done that I should not afraid, he will take good care of me" (Female, Permanent Resident, age 49, 3 years in Canada). She also explained that physicians provide information and communicate effectively about test results and give advice on positive health behaviours where needed.

In contrast, about three participants expressed a contrary view of their interactions with providers, with an additional two participants expressing both favourable and unfavourable opinions of different health care personnel in Canada. About four participants in various ways implied or stated that they feel their health care provider/ physician does not listen to them or take note of their complaint or issues. They reported that they felt their concerns were ignored or pushed aside in some cases. For example, Dotun mentioned "the doctors seem to be in a hurry. Most times you tend to have this impression that they are actually not listening to you" (Male, Permanent Resident, age 40, 3 years in Canada). Bunmi who is a caregiver and a mother explained a scenario where her complaint was not given the priority she felt it should have been given. Here, she stated that:

> I have had to see a doctor myself when I was pregnant and I was vomiting badly. I wasn't tolerating anything. And then I was really weak but you know, I just felt that I had this high pain threshold so I could manage myself. And I got there [emergency room] but because I was standing, they felt I was fine and I had to go home. When you know how you feel and you really can't explain it, because no one feels the same way, maybe it was one of those days too. Like I just felt you know what, this was not right, not even a test was conducted (Bunmi; female, Permanent Resident, age 32, 2 years in Canada).

This participant also explained that upon delivery through caesarean she had a surgical complication as she was bleeding, but the doctors refused to reopen and check the stitches and the bleeding as they claimed that they wanted to prevent an infection. She stated her husband is also a doctor elsewhere and his concerns about the stiches were ignored and as a result she

acquired an infection and had to be readmitted for five days during a time that she was a new mother. She expressed great dissatisfaction with this experience as she believed that her suffering could have been avoided if they had listened earlier and this caused her a great deal of stress.

Likewise, three participants also reported that some health care professionals were quite uncaring and standoffish in their interactions, even inconsiderate to the patients. With respect to unfriendly physicians, Dotun noted: "there is this particular woman that is our family doctor, first whenever I go to her clinic she does not smile. It as if there is a quarrel, she is under pressure …" (Male, Permanent Resident, age 40, 3 years in Canada). He also stated that this physician is quite rigid in her conversation or communication as he mentioned:

> …even our conversation is not as dynamic as you would expect conversation with a doctor to be. Usually it's a one liner. How do you feel? This is it. This? Yes. Okay. It is usually like a one liner kind of response. Do you feel pain? No. Can you lie down? Tell me if you feel pain here. Okay can you stand up? Can you dress up?

Dotun proceeded to express that physicians can be inconsiderate of their patients' time:

> There is never a time I go in for an appointment and I get to see the doctor on the dot … I mean you know at the exact time I am supposed to … Usually it's like 15 – 20 minutes and you know the impression is time is money as far as they are concerned but they have no respect for your own time. There is no respect for your time as a patient. You can be in a clinic waiting for a doctor for 30 minutes. It doesn't matter if you have to go back to work, it doesn't matter if you are on break. You just have to wait. Not minding that you had an appointment booked for a particular time.

Yemisi who is a science student also shared her impressions of uncaring and inconsiderate physicians in talking about her family doctor: "that guy should not be a doctor. Because the way he talks and the way he breaks down news to you. Like he can practically tell you you're dying but, 'everyone dies'" (Female, International Student, age 25, 1.5 years in Canada). She added:

> I feel like he doesn't really care. That's the attitude I get from him. Like he doesn't really … you know when you are just doing your job because you have to, that's the vibe I get

> from that physician that he is just doing it because he has to and I have heard about him too. Like after I had my experience with him and I was talking to somebody else I didn't even mention his name and she mentioned his name. So that physician has a problem.

For Yemisi, who believed all practising doctors complete necessary technical training, there were deficiencies in how Canadian doctors interacted with patients: "I believe the Nigerian system in terms of attending to patients is way better than here."

This section also reveals that not only might participants hold positive and negative views of their experiences in their interaction with health care providers, but they may hold such views simultaneously depending on the standpoint from which they speak. For instance, a participant speaking from standpoint of a mother seeking care for her children expressed a positive view of her children's doctor yet when relaying her personal experience, she expressed a negative view of physicians.

Extending the issue on negative patient provider interactions, participants shared their views on discrimination in the health care system and this is explored below.

5.2.4.1 Perceived Discrimination

Participants were all asked if they ever felt that they may have been treated differently by health care providers because of their race. Notably, five participants indicated that they have never felt discriminated against by health care providers (this will be addressed further in the discussion). Three participants did share personal experiences of discrimination within the health care system, and one participant (Nike, noted earlier) shared her experiences of discrimination outside the health care system. Of the three participants referring to health care experiences (Ijeoma, Dayo and Dotun), only two could say with certainty that they were discriminated against while the third participant was quite uncertain. For instance, Ijeoma who is a university student described her personal experience with an attending/on call physician during her

hospitalisation. Importantly she interprets this interaction as signalling interpersonal discrimination:

> He didn't even ask me how I was. I felt like he neglected me because of my race or something like that. I felt that he was racist to be honest because he was your typical white Canadian and he was so not affected by everything … I don't know how to put it but I just felt not wanted at all … he didn't have that care in his eyes. Like he didn't even talk to me at all. And it was not like I wasn't able to talk. I was able to talk. I wasn't so incapacitated that I wasn't able to talk. I was able to talk he didn't talk to me, he just told the nurse change her drip or something like that then he just left (Ijeoma; female, International Student, age 20, 2 years in Canada).

She proceeded to explain how her concerns about racism were validated by another doctor who expressed that he had received similar complaints about that same doctor. Ijeoma also stated in relation to this incident that:

> I quite understand that that there are some days where a doctor or a nurse would not just be in the mood. But that doctor, trust me he is plain racist I don't even want to say anything else about it. But yeah, I know when someone is having a bad day or had a bad day and doesn't want to engage in any conversation. But for the other doctor to tell me that he has also had the same complaints from other people. Yeah my case is solidified.

Interestingly, Ijeoma also stated that she was advised by this doctor to forget the experience and not take it personally ("'don't let that get to you' was what that doctor told me"). Ijeoma, who is of the mid-upper class in Nigeria, stated that she would not have been treated like that by doctors in Nigeria, adding: "we are not so diverse in Nigeria. Almost everybody is black. So you cannot be a racist in Nigeria to your people. It's not just done but here [in Canada] trust me there is racism in the hospitals" (Female, International Student, age 20, 2 years in Canada).

Dayo believed that racial discrimination is quite subtle in Canada as he explained that:

> …racial discrimination is not very obvious, it's hidden. So except people that … but I always ignore when I see any form of discrimination anywhere I find myself including with health care providers. It's there but when I experience such things I ignore and I move on. But you can't deny the fact that racial discrimination exists. (Male, International Student, age 32, 2.5 years in Canada)

He then described a scenario in which a lack of transparency about triage and access contributed to his interpretation that discrimination may have played a role:

> Like coming before somebody to a clinic and we were supposed to be on a queue, and I was put aside and they attended to somebody else and I will just see that without any explanation if there was an explanation maybe I would say that maybe the person came earlier and went somewhere. But without explanation I would assume it's because of my colour I was on a queue and pushed aside and somebody else that came after me was attended to.

Dotun, who is a wage earner and of the middle class, also opined that he may have been discriminated against due to the fact that his family doctor always seems rigid, standoffish or unfriendly in her interactions with him, restricting conversations to yes or no responses and always seeming to be in a rush. He stated that she might be discriminatory, but was hesitant to conclude this for certain because he cannot see how she interacts with other patients: "although I have not had the opportunity to see her relate with other people, but I am not so convinced that she not discriminating" (Male, Permanent Resident, age 40, 3 years in Canada). In this case, Dotun hesitated to legitimise his own concerns about feeling discriminated against.

Notably, all participants shared similar responses to experiences of interpersonal discrimination, whether experienced within or outside the health care system. Participants tended to normalise discrimination by brushing it aside and moving on from such experiences and not dwelling on them to prevent a greater emotional upset. Nike, for instance, stated: "I just waved it off like it is okay" (Female, International Student, age 20, 2.5 years in Canada). Dayo also stated:

"I felt very bad. I felt bad, but I ignored it, and I moved on. I felt bad initially like my mentality always is that when I experience that I just move on with my life" (Male, International Student, age 32, 2.5 years in Canada).

These kinds of experiences can result in trust or mistrust in such physician's abilities; additional issues related to trust are further explored below.

5.2.5 Trust

Two participants expressed that they do not trust their physician or the Canadian health care system. Yemisi expressed her mistrust of the qualification and ability of her physician by stating "I am a [name of school] student which is a good thing cause we have health insurance and we have our clinic so I went and I was given a physician that I don't think is a very good physician" (Female, International Student, age 25, 1.5 years in Canada). Bunmi also explicitly indicated her lack of trust for Canadian health care which was borne from her negative surgical experience of post-surgery complications. This distrust is further revealed in her outlook as she also stated "so sometimes you feel really at risk when you want to access. You are not even encouraged to go because most times because of the disparity" (Female, Permanent Resident, age 32, 2 years in Canada). Nike also expressed her distrust for the Canadian health care system due to the long wait time and the outcome of her visit to a family doctor where she was advised to drink fluids and rest as this was unsatisfactory to her. This resulted in her choosing to self-medicate by getting over the counter medications or medications used or recommended by her friends to treat herself (for minor conditions/ailments) especially without prescription instead of seeing health care professionals in the future; she also expressed that most of her friends share this same view and advise each other to self-medicate (Female, International Student, age 20, 2.5 years in Canada).

In contrast, Funto expressed her trust in her physician based on her impression of his knowledge, as indicated in the following quote: “but the way he talked when I was listening to him I know he that had experience in that area. I know he was saying” (Female, Permanent Resident, age 49, 3 years in Canada). Upon her decision to receive treatment after talking to this specialist physician, this same participant further outlined the successful treatment outcome, with which she was pleased.

Thus, participants’ trust and mistrust for physicians are borne from their interactions and experiences with such health care providers and this is often influenced by the outcome of treatment strategies or surgical procedures as illustrated above. Further, successful health outcomes are also influenced by the availability of resources and infrastructures, which is explored below.

5.2.6 Availability of Resources/Infrastructure

Two participants expressed that the Canadian health care system is well funded and as a result providers have access to resources and advanced diagnostic equipment, which improves health care delivery and treatment strategies. In relation to access to resources, Tobi explicitly contrasted Canada with Nigeria, as he stated: “if you start from availability of resources the health care system here [in Canada] they have the resources than we do [in Nigeria]” (Male, International Student, age 32, middle-upper class 2.5 years in Canada). In relation to infrastructure and equipment Yemisi, also making comparison to the situation in Nigeria, stated that:

> Infrastructure wise obviously… I don’t think there is an MRI in Nigeria if there is maybe just one. I am not sure. But obviously there are more facilities here. There are more ways to actually discern what is wrong with the patient here. For instance I had to have an ultrasound done and an MRI because the ultrasound is not really … like ultrasound is not definitive. The ultrasound would show you something but it might not show you a clear picture. An MRI is a better imaging system which would be able to detect what exactly is

> wrong with the patient. We do not have that in Nigeria. We do not have several other facilities in Nigeria and treatment wise, here [Canada] might be better than Nigeria because they have the infrastructure and facilities to do so (Female, International Student, age 25, 1.5 years in Canada).

Thus, these participants acknowledge the role of health care infrastructure and resources in ensuring favourable treatment outcomes for patients especially at the stage of illness diagnosis, as the stated equipment gives a better picture of the problem and as result gives room for more effective treatment planning.

Overall, the research findings indicate that participants have a mix of negative and positive experiences in accessing and receiving health care services both in Canada and in Nigeria. In recounting their experiences with health care in both countries, core themes common to both types of accounts included ease of access, speed of service delivery, attitude and demeanor of health care practitioners, indicating that these were particularly important aspects of health care services.

Access to health care services was important to participants as they relayed their health care experiences both in Nigeria and in Canada. Participants' acknowledged the fact that access to quality health care services hinges on ability to pay in Nigeria and this led to their favourable view of the Canadian publicly funded health system as they note that cost prevents some groups of people from gaining access to health care in Nigeria. Despite this all participants indicated that access to health care in Nigeria was quite easy for them. However, about three participants indicated that access to health care in Canada is also easy specifically with respect to getting appointments and walk-in clinics. Nonetheless, about six participants also indicated that they experienced some form of challenges in accessing health care in Canada as they explained that the process to gaining access to health care services was hindered by delays and long wait times for services. Further, of these six participants, two participants held both positive views (easy

access) and negative ones (hindered access) in relation to different health care services – delays in emergency rooms and faster services in walk-in clinics.

The speed of health care access and service delivery was also important to participants, as it was believed to be important for health outcomes. All but one participant stated that health care service delivery in Nigeria was quite fast. One participant illustrated this with a scenario of a successful same day emergency surgical procedure. In contrast, another participant perceived delays in access especially in specialist services, since her attempts to access specialist care for a nose condition were futile and filled with delays and cancellations of surgical procedures. Upon her eventual successful access, the treatment did produce a favourable outcome – cure. In relation to service delivery in Canada, most participants indicated that speed of access and service delivery is quite slow and full of delays by virtue of long wait times. However, one participant expressed that access to health care in Canada is quite fast and easy, as he stated that he gets attended to quickly whenever he goes to a clinic or hospital.

Another important theme as identified by participants is the attitude and demeanor of health care providers. This is notable because participants tended to describe their interactions with health care personnel and in some cases expand on the choices and decisions they made resulting from such interactions. About six participants described their interaction with physicians in Nigeria positively, stating that the doctors were friendly, caring, concerned, and so on. All but three participants in relation to health care in Canada also characterized doctors as "nice"; other participants had interactions with doctors they believed were uncaring and inconsiderate, rude and unfriendly, and even racist. In some cases, these impressions stemmed from a lack of response by the health professionals to medical concerns, or rushed, brief

interactions. In one case, a participant believed her doctor was racist because he doctor ignored her completely and never addressed her directly even when she was awake.

Further, this research also revealed that participants' interpretation of their health care experience in Nigeria also influenced their impressions of their health care experience in Canada. Participants who had positive experiences with accessing and receiving health care services in Nigeria tended to be more critical and have higher expectations of the Canadian health care system. The reverse is the case for participants who had negative and in some cases life threatening experiences in Nigeria as they tended to be more open minded about the Canadian health care system (as in one case where a participant did not view the long wait time for a corrective surgery negatively but rather focused on the correct diagnosis of his ailment). This shows that the pre-migration experiences and expectations of participants had an impact on their outlook on the Canadian health care system, be it positive or negative. For instance, one participant expressed his disappointment in the Canadian health care system; he expected that health care services would be easy to gain access to in Canada especially due to the public health care system, but upon arrival he found that health care access was hindered by long wait times and other forms of delays. In contrast, for another participant, the Canadian health care system was quite fulfilling, as she was living with and managing a health condition before her arrival in Canada and upon arrival she was able to get a proper diagnosis and successful treatment. Thus, participants with positive pre-migration experiences had higher expectations of the Canadian health care system which was in most cases unmet while participants with negative pre-migration health care experiences in Nigeria were more open minded and accepting of the Canadian health care system as they tended to focus on the positive aspects of the system – specifically, diagnosis and treatment outcomes.

CHAPTER SIX

Discussion and Conclusion

In this chapter, I discuss the theoretical implications of the findings of the study as well as reflect on the findings in connection to existing literature on experiences of African and specifically Nigerian-born residents' experiences in accessing health care services in Canada, including barriers that hinder their access to quality health care services. This is with the aim of linking the study's findings to the theoretical framework and existing literature in order to note the similarities and differences. Prior to this, however, it is salient to note that there were no major differences between participants of permanent and temporary (international student) residence status in terms of their experiences with accessing health care services in Canada. None of the participants had issues with the cost of health care services in Canada but some participants (both temporary and permanent residents) had issues with various aspect of health care delivery in Canada. To further illustrate this, in Table 2 an outline is provided to summarize and compare key research findings related to participants' interpretations of health care in Nigeria and Canada; following this, a synthesis of core findings related to how participants interpret care is elaborated.

Table 2: Participants' interpretations of health care in Nigeria and Canada

Themes	Nigeria	Canada
Access	• Easy access to health care services • No appointments required • Faster services • Slower services in public hospitals • Corruption and inequality • Readily available physicians	• Easy access to health care services • Long wait times • Appointments are required • Easily scheduled appointments for specialist physicians • Slower service delivery

	• Lack of specialist physicians	
Cost of Services	• High cost of quality services • Employment health insurance	• Publicly funded health insurance • High cost of ambulance care
Quality of Services	• High standard care • Substandard service • Complication free surgery • Inconclusive surgery • Medical error • Poor training • Lack of medical equipment	• High standard care • Post-surgery complication • Successful surgery • Rigorous training • Availability of medical equipment
Attitude and Demeanour of Health Care Practitioners	• Nice, friendly and caring physicians • Rude and uncompassionate nurses • Open and easy communication • Informal interaction	• Friendly and caring physicians • Inconsiderate and rude physicians • Rigid communication • Inattentive physicians • Perceived racial discrimination by physician

The table above reveals that participants had experiences and perceptions that in most (but not all) cases, were comparable to each other across countries of origin and settlement – Nigeria and Canada. It also indicates several core themes reflecting what matters to them in evaluating and making sense of health care experiences in either country. Findings related to each of these themes will be summarized below. First, the most important issue to participants is their prompt access to required health care services. Participants mentioned issues involving the speed of service delivery, ease of access, availability of physicians, and so on. They also tended to offer positive and/or negative perspectives in terms of their satisfaction and dissatisfaction with services received and the processes of accessing these services both in Nigeria and Canada. They did this by comparing their experiences with the experiences of others, legitimizing their

experiences by sharing examples from personal experiences, and describing interactions primarily only when these interactions were characterized by dissatisfaction.

Participants' overall impressions of and views about their experiences with the Canadian health care system were influenced by their pre-migration expectations and experiences with the Nigerian health care system. For instance, in relation to the theme of access, six participants who expressed a view of easy and timely access to health care services in Nigeria went on to state that access to health care services in Canada involves numerous delays related to long wait times in family doctor's office, in emergency rooms, for diagnostic tests and for specialist appointments. This was, for some (e.g., Yemisi, Dotun, Bunmi), contrasted against experiences of easy access to health care services in Nigeria, albeit within a more inequitable system highly grounded in the ability to pay for services (and all participants identified as being on the middle class or higher in Nigeria). Participants generally viewed long wait times as unacceptable, although the greater availability of resources and infrastructure – diagnostic equipment such as MRI – in Canada was noted as beneficial.

In contrast, participants who had more negative experiences within the Nigerian health care system tended to be more positive in their assessments of the Canadian health care system This included Funto, for whom the ultimate successful outcome of the treatment process in Canada was more important than her three month wait for the initial specialist appointment (suggesting the outcome was more important to her than the delay).

Another important theme revealed in the data concerns participants' impressions of the quality of health care services. In relation to this theme, participants tended to express views of standard and substandard health care services in both countries quite frequently, and tried to validate these opinions again by drawing comparisons or contrasts between services received in

both countries (as well as the experiences of others such as friends and acquaintances). Both Tobi and Dayo, for instance, sought to validate negative impressions of Nigerian health care and explain their favour for Canadian health care by providing examples of misdiagnoses in Nigeria (experienced by themselves and/or their friends). In contrast, Yemisi explained her negative impression of the quality of Canadian health care with respect to her less than satisfactory assessment of her family doctor's lack of caring and concern (she also drew on her friend's experience with this same doctor).

Perhaps in part because they had personally experienced misdiagnosis and medical error in Nigeria, both Tobi and Dayo mentioned that medical training in Nigeria is not as rigorous as that in Canada and that some physicians are not actually qualified to treat patients and as such, they provide substandard care. The issue of training did not really arise in participant evaluations of the Canadian health care system – it was almost always assumed that they have the proper training. As discussed below, however, Canadian health care professionals may nonetheless be viewed as less than adequate in their 'bedside manners' or patient interactions.

Indeed, another important theme identified in participants' interviews relates to the interaction between health care practitioners and patients – and specifically the attitudes and demeanour of health care practitioners. Most participants described physicians in Nigeria positively as friendly, nice, caring, attentive and concerned, and so on. Only two participants had negative views of physicians in Nigeria and such views were linked to their experiences with misdiagnosis and medical error rather than interpersonal styles. Interestingly and in contrast, all but one participant who had mentioned nurses in their interview expressed a negative view of Nigerian nurses as rude, mean, and unprofessional, whereas nurses in Canada were described as nice, friendly, caring, efficient, and so on.

Four participants (e.g., Bunmi, Yemisi) were critical of doctor-patient interactions in Canada; when they felt the doctors were rigid and rushed in their interactions, they interpreted the doctors as inconsiderate, rude, and unconcerned with their health. These kinds of findings indicate the key importance of provider responsiveness to health care concerns raised by patients, for patient interpretations of the compassion or care of health care providers.

Further, in relation to concerns about interpersonal discrimination both in and outside the health care system, it is notable that participants shared similar responses to interpersonal discrimination, whether experienced within or outside of their health care interactions. Specifically, participants tended to normalise discrimination by brushing it aside and moving on from such experiences and not dwelling on them to prevent a greater emotional upset. This will be discussed further in the following section.

6.1 Theoretical Implications: Critical Race Theory

The purpose of this study was to explore the experiences of newly arrived Nigerians in gaining access to health care services in Canada, specifically in Winnipeg, Manitoba. In order to gain an in-depth understanding of the issues involved, participants from this group were interviewed and interview transcripts were analysed through qualitative methods and by drawing on Critical Race Theory. Using this approach revealed specific barriers which Nigerian immigrants face in the process of gaining access and in receiving health care services that are structural, personal and interpersonal in nature. Critical Race Theory is concerned with issues surrounding racial subordination, prejudice and inequality in relation to socially constructed race (Graham, Brown-Jeffy, Aronson, & Stephens, 2011). Further, in its process/analysis, Critical Race Theory focuses on the viewpoint of those from racially marginalised groups in presenting stories of discrimination while also seeking and actively arguing against racial discrimination as

"race" is first and foremost a social construct (Parker & Lynn, 2002). Therefore, the experience of racism or discrimination is not an abnormal experience for the racialized or people of colour. Thus, in using Critical Race Theory one can explore participants' experiences while also taking note of their world views which can then be used in advocating for "inclusiveness, diversity training among service providers" (Kereyo & Flomo, 2012, p. 106).

An important aspect of Critical Race Theory is its focus on the experiences of discrimination from the perspective of the marginalised, through story telling or experience-sharing. As such, it fits well with a qualitative approach to data collection. Moreover, Critical Race Theory is an important way by which we can connect individual stories to an understanding of inequitable structural forces that generate these stories and influence their interpretation by participants.

Four participants in this study believed that they had experienced some overt form of racial discrimination in Canada (three within the health care system). Ijeoma expressed that racial discrimination in doctor-patient interactions sometimes goes unchecked. Indeed, patients often lack any suitable mechanism for making these kinds of complaints to an independent body, to facilitate their successful investigation and resolution.

As Dayo, expressed, discrimination in the Canadian health care system can also subtle and hidden, not obvious. Dayo's interpretation of being passed over by other patients several times without explanation while waiting to see a physician at a clinic is notable, because he interpreted this as a reflection of racial discrimination. He has no way of knowing for certain whether others at the clinic had more urgent conditions, or whether there was some other explanation. This situation illustrates a weakness of Critical Race Theory which is the difficulty in proving that this participant was discriminated against and as opponents of this theory have argued it relies on the subjective emotions of participants (Farber & Sherry, 1995). Despite this

criticism, it can still be argued that this example illustrates the power of perceived racism, as well as the important implications of a general lack of transparency and communication about triage in health care service delivery systems.

As noted earlier, participants who had experienced racial discrimination tended to respond by overlooking or ignoring it. Such responses may be linked to feelings of powerlessness in being able to prevent or directly address such behaviour; in the absence of feeling able to control the experience, participants may try to avoid it in order to protect their personal emotional and mental wellbeing. This process may generate a desire to forget such experiences as well as a reluctance to share them within a research interview. In other words, this may account for the denial of discriminatory experiences among four participants.

Nonetheless, participants expressed feeling badly when they experienced discrimination (Ijeoma and Dayo). Interestingly, despite experiences of discrimination, all but one participant indicated that they have no racial or cultural preference in their choice of a physician when asked this during the interview and this was echoed by the other participants that did not have any discriminatory experience. They indicated that they want any physician who can provide the best possible service to them, is willing to listen to them and who cares about their wellbeing. Thus, Critical Race Theory was not the best analytic guide for this research as only four participants reported issues with discrimination and of those four participants, three did not have any racial preference for their health care provider but were more concerned about receiving the best service. Therefore, a better analytic model might be a patient satisfaction model (adapted for qualitative data), which explores patient expectations of and experiences in receiving care in assessing satisfaction or dissatisfaction with health care service (Ahmad et al., 2012)

Consequently, the findings from this study suggest that a better, more inclusive health care service model which includes the provision of culturally competent and patient-centered

health care services has the potential to improve Nigerian immigrant's health care experiences, since they may feel health concerns would be heard and addressed and they would be actively involved and informed in their treatment process. This is important as their experiences with health care providers in Nigeria was open and friendly and as a result the rushed and delayed service delivery system was unsatisfactory for them. Educating newcomers about how the system works may also be also very important.

6.2 Connections to Existing Literature on Access to Health Care Services

This study's focus was in understanding the experiences of newly arrived Nigerians in the Canadian health care system with specific focus on the process of accessing and receiving health care services, while considering cultural influences on interpretations of such experiences. As Dunn and Dyck (2000) stated, immigrants face barriers to accessing health care services in Canada that are in part related to their social status and economic conditions; these barriers influence their health care utilisation and consequently their health status. A number of studies have identified barriers to accessing health care services which are structural (rushed services, high cost of prescription medication, long wait times; for tests, specialist appointments, emergency room, and so on), personal (poor language skills, lack of knowledge about health care system) and interpersonal (lack of social networks, discrimination and so on) in nature (Asanin & Wilson, 2008; Dastjerdi et al., 2012; Newbold et al., 2013). For international students in Canada, some barriers to accessing health care services include: lack of knowledge about the health care system and health insurance, triage issues, long wait time, transportation cost to clinics, divergent understanding medication use (Burgess et al., 2016).

In relation to service models, the present study found that although participants had a somewhat holistic understanding of health, this was complex and not straightforward. For

instance, although about three participants expressed a predominantly biomedical view of health, they also expressed views that emphasized a good quality of life as well as the supernatural/spiritual. About five participants expressed beliefs in the role of divine supremacy in keeping them alive and in good health. Participants' dissatisfaction with Canadian health care may be due in part to their more holistic views of health. A holistic view of health can lead with particular dissatisfaction with health care delivery that is 'rigid' and 'rushed' (e.g., as two participants described it). It can also lead to dissatisfaction with provider-patient interactions, such as when Dotun described his family doctor as asking a series of "one liner" questions about the absence or presence of pain and limiting visits to about 15 minutes per consultation, or Yemisi refers to providers as unconcerned and inattentive.

Participants also called for a more patient-centered approach to health care delivery in Canada as they had experienced issues related to rushed services, feelings of being ignored or not listened to and they also felt their physicians were often unconcerned/inconsiderate. A patient-centered model of health care delivery means that physicians and other health care providers acknowledge the social context of every patient – i.e., their immigrant status and potentially differing views about health and health care – and listen to, inform, respect as well as involve patients in their care decsions by honouring their wishes – although not mindlessly (Epstein & Street, 2011).

The findings of this study provide further support to findings from other studies that immigrants to Canada do face significant barriers to accessing health care services, and that racialized foreign-born residents can also experience some forms of discrimination in the health care system. Health care discrimination as experienced by the Nigerian-born participants in this study are similar to findings from other studies on other non-European source country residents in Canada, which reveal that participants perceived that they were being discriminated against

because they felt they were being ignored by their physicians (Dastjerdi et al., 2012). This is similar to the experience of a participant in this study (Ijeoma) who also felt discriminated against by a doctor who also ignored her by refusing to address her.

Perhaps the most common concern and one of the most important barriers experienced by this particular group of newly arrived Nigerian participants was the issue of long wait times. This was a great concern to participants as they expressed that they are hindered by unacceptably long wait times at various points in health care access and delivery, and some reported experiencing outcomes such as pain and worry in this regard. This may also have been a major concern because they all reported past experiences of prompt and speedy service delivery in Nigeria (i.e., that their doctors were always available at the patient's convenience). Furthermore, on this issue, several studies on access to health care by the non-immigrant population in Canada also report similar findings about long wait times for health care services (Barua, 2015; Day, 2013; Esmail, 2009). Findings from the current study are also similar to the studies on the general Canadian population, that find that long wait times (diagnostic tests, specialist appointments, and so on) hinder the optimal access and sometimes utilization of health care services; however, one difference here is that Yemisi reported a longer diagnostic test wait time (four to six months) than the reported national average wait time of 10.4 and 4 weeks respectively for MRI and Ultrasound in 2015 (Barua, 2015). She interpreted this wait time as unacceptably long and was concerned about worsening illness, suffering and the risk of death.

Language barriers, specifically poor language skills did not emerge as an issue for participants in this research particularly since the participant group consisted of a large proportion of international students, and because English is the official language of Nigeria. All interviews in this research were conducted in English language and although some participants used some slang and expressions that were distinctly Nigerian, they were all able to

communicate in English quite easily and as a result, language barriers were not salient for these participants. Further, the socio-economic status and educational background of participants (they were all middle class or higher and they all had formal education) may have influenced their abilities to communicate clearly with health care providers. The nature of the participant group likely reflects the recruitment methods, since participants were recruited through snowball methods – students recommended other students and parents who were also educated. Thus, a study of Nigerian immigrants with more diverse socio-economic backgrounds might generate more comprehensive findings.

The impact of the high cost of prescription medication, identified in other research, also did not emerge in these research data. This could also be due to the fact that most participants were from middle or upper class backgrounds and many were students with health insurance covering a portion of the cost of prescription medication. As such, the lack of health insurance also did not emerge in the research data as a barrier. Rather, participants who mentioned health insurance indicated that they had provincial health insurance and praised the publicly funded system. Their access to health insurance might have been influenced by their province of residence as well as their length of residence and their immigration status. The five participants who were international students all had access to the provincial health insurance and health cards. Access to health insurance might be reflected more strongly in studies of more recently arrived and undocumented immigrants.

A lack of social networks as noted by Dastjerdi et al. (2012) caused Iranian immigrants to ignore their health concerns since it was not culturally appropriate for them to ask for help. In the present study, Funto suggested that in contrast, in Nigerian culture it is culturally acceptable to offer and seek aid from others when needed. She herself became connected to her current family doctor through the referral of a fellow Nigerian whom she met on the bus. Participants also

spoke generally about experiencing some positive social networks here in Canada. However, the loss of former support network connections was identified by Nike as burdensome in general (not specific to health care).

A study of international female students in a Canadian university finds that they sometimes had issues with understanding the Canadian health care system that was related to medical /health insurance, the triage process and so on which resulted in a fear of falling ill due to lack of support networks to care for them if needed (Burgess et al., 2016). Among the international students in the present study, one participant (Dayo) expressed a view of being passed over while waiting for health care, which can be linked to his lack of knowledge about triage in the Canadian hospitals. This is similar to the finding that international students with prior experiences in a first come, first served health care system often get confused and are unfamiliar with the Canadian triage system where the critically ill are attended to first despite their arrival time (Burgess et al., 2016).

Indeed, two participants (international students) indicated issues related to their knowledge about the Canadian health care system and how to access it. One participant (Nike) expressed that while operating from her understanding of the Nigerian health care system, went directly to the hospital's emergency room when she had a head and stomach-ache rather than a walk-in clinic which resulted in her having to wait several hours and eventually she was unable to see a physician. As a result of this negative experience of delay in accessing health care services, this participant (Nike) goes on to state that she now chooses to self-medicate than to go to hospital or clinic and she also advises her friends to do the same. This is similar to the finding of Burgess et al (2016) who finds that international students choose to self-medicate over facing the complexity of the Canadian health care system in relation to the triage, insurance process, wait time, and so on as their parents often get them first aid boxes containing different

medications although most of the participant could not explain the directions of use for those medications. Another participant (Amira) mentioned her lack of knowledge that ambulatory care is not covered by the insurance; this did not affect her access to care yet caused some shock when she received the bill weeks later. Thus, immigrants need to be informed about the use of walk-in clinics, the provincial health insurance specifically covers as well as triage in the Canadian health care system.

A lack of culturally appropriate services was indicated as a potential barrier by two participants (Dotun and Yemisi) who expressed improved doctor-patient interactions that were longer, more free flowing, and interactive, and that doctors should be more concerned about their patients' well-being. Improved doctor-patient interactions is also beneficial to Canadian-born residents as concerned and attentive doctors improve patients' health care experiences and consequently health care services utilization.

6.3 Conclusion and Recommendations

In conclusion, from the perspective of participants in this study, both the Canadian and the Nigerian health care systems have their strengths and weaknesses. Canada, they believe, has more public funding/reduced personal cost, and more effective health care facilities and equipment in contrast to the Nigerian health care system. However, their experiences within the Canadian health care system introduced issues such as discrimination at the interpersonal level that may affect their utilization and access, and consequently their health status.

The process of migrating to a new country comes with a number of pre-migration expectations and experiences that influence eventual settlement experiences. Over the years, the Canadian immigration rate has steadily risen and as a result the immigrant population make up about 20.6% of the total population of Canada (Chui, 2013) with Nigeria as a source country

ranking highest in Africa. Thus, it is of great importance to ensure the settlement and sense of belonging of Nigerian immigrants to Canada of which prompt access to health care services when required plays a role. One aspect that contributes to the settlement experience and consequently the sense of belonging of immigrants is the health care system, specifically, access to health care services. This research reveals a number of themes that influence participants' health care experiences including ease of access, cost of services, speed of access and service delivery, trust, availability of resources and the attitude and demeanour of health care practitioners. Experiences described in relation to these themes were those both positive and negative, and these experiences were evaluated and interpreted in complex ways. However, the experience of being discriminated against created particularly negative emotions like sadness and hurt as much as participants strove to ignore these experiences. Thus, there is a need for social inclusion through the provision of multicultural and anti-racist health care services in Canada which take into account different cultural approaches and understanding of health as well as actively seeking means and strategies to manage and reduce wait times for any form of health care services.

6.4 Program Suggestions

One avenue for improving the access and receipt of health care services is to facilitate the provision of culturally appropriate health care services through shifting policy and practice towards patient-centered model that focuses on multiculturalism and anti-racism. A pilot program on culturally sensitive health care services delivery could be created with incentives built into the system to support this model which takes into account the differing world views of patients when delivering services. Furthermore, professional agencies and governmental bodies should also create pilot programs which promote more positive interactions between doctor and

patients and cross-cultural training by sponsoring seminars and conferences on this topic. Finally, discrimination within the health care system and settings can and should be addressed in the code of ethics applicable to the medical profession in Canada and defaulting doctors should be sanctioned and retrained. Health institutions should device ways of getting feedbacks from patients by having dedicated emails and suggestion boxes at visible locations where patients can make complaints and suggestions.

6.5 Suggestions for Future Research

Future research can be conducted with more focus on the issue of racial discrimination within the Canadian health care system, to examine and assess its prevalence using large-scale datasets, as well as by inviting and giving voice to those who have been marginalized by these processes. Lastly, future research with larger and more diverse samples (including those from low SES backgrounds, older adults, international students etc.) should seek to more comprehensively document and explore the experiences of older adults in accessing the Canadian health care system. The ultimate goal of this work would be to provide enhanced knowledge to further help address structural barriers to care that are crucial for the inclusion and settlement of all foreign-born individuals in Canada.

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Appendix I

Question Guide

Introduction:

I am interested in hearing about your experiences with health care services in Canada, but first I have a few preliminary questions.

- **Demographic Information**
  - "What is your state of origin, ethnic or cultural affiliation in Nigeria?"
  - "What is your gender"?
  - What is your year of birth?
  - "Do you practice any religion?" "What is your religion?"
  - "In what social or economic class might you place yourself: lower, middle or upper class?"

Thank you. Moving on, we are going to talk about a range of issues related to health care but first I would like to know more about your own history.

1. First, can you tell me how you came to be in Canada?

- Probes: can you tell me more; how long ago was this; what was that like for you?

2. Now that you're here, what has your experience in Canada been like, overall?

- Probes: tell me more; can you provide an example; how have you felt about this?

3. Next, I'm wondering if you can tell me a bit about how you view health. In other words, for you, what does it mean to be healthy?

- Probes: can you tell me more; can you give an example?

4. Can you tell me about your experiences with accessing health care in Nigeria?

- Probes: Can you give any examples; tell me more; what was that like; what about experiences with particular health care professionals?

5. Can you now tell me generally about your experiences trying to find or access health care services here?

- Probes: "Can you give me an example?" Can you give me another example? What was that like? How did you feel? Tell me more; [Or reiterating a phrase used by the participant followed by a pause].
- As relevant/needed, questions such as: What service did you access and why did you decide to go there? How did you find out about this? What has stopped you from using health care services? What has helped you access health care services?

6. Can you tell me in a bit more detail about any of your visits or uses of particular services?

- Probes: How were your interactions with the health care providers (doctor, nurse, etc.)? How did you feel during this interaction? What happened next? Can you give an example?

7. Based on your personal experiences, tell me about your overall impressions of Canadian health care.

- Follow up Question: How does this compare or contrast to your impressions of health care in Nigeria?
    - Probes – tell me more; can you give an example.

8. In your experience, have you ever felt that you may have been treated differently in any way by health care providers because of your racial background?

- Probes: Can you give me an example? What was this like? How did you feel?

9. Do you have a primary care physician? IF YES: Is he/she Nigerian? African? IF NO: Would you want a Nigerian/African physician if you could have one? Why or why not?

10. Can you recommend any area of improvement in the health care services in Canada that would help you better?

- **Thank you for your time.**
- **Request for other Participants**

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Appendix II

Informed Consent Form

Research Project Title:	Nigerian Immigrants' Experiences Accessing and Receiving Health Care Services in Canada
Principal Investigator:	Efe Oghogho Ehigiato ehigiate@myumanitoba.ca
Research Supervisor:	Dr. Laura Funk, Associate Professor, University of Manitoba. 204-474-6678 /Laura.Funk@umanitoba.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Project Description:

"Nigerian Immigrants' Experiences Accessing and Receiving Health Care Services in Canada" examines the experiences of Nigerian immigrants with the Canadian health care system. The purpose is to explore and better understand how Nigerian immigrants interpret their experiences in gaining access to health care services including any barriers they may have faced in the process. For this project I expect to interview approximately 15 participants. I will ask you questions about your experience with the Canadian health care system, including your overall impressions. The purpose of this research is to draw attention to the possible health care needs of immigrants.

Participation and Time Requirement:

Your voluntary participation will involve one interview in-person which may require approximately 1 or 1.5 hours of your time. As participation in this project in voluntary, you may decline to answer any question or withdraw from the study at any time without any negative

consequences. If at any point you decide to withdraw from the study, the interview will be stopped and you may choose whether the information obtained at that point can or cannot be used in the research. This interview would be recorded with your consent using a digital device and later transcribed by myself. A reward ($10 grocery gift card) will be given to you as a form of appreciation and acknowledgment of the time you spent or expenses incurred while participating in the interview even if you choose to withdraw from the research.

Confidentiality

Any information gathered in this research will be kept strictly confidential but due to the fact that the Nigerian immigrant community in Winnipeg is fairly small, there is a slight risk that you might be identifiable from your responses in the research work. But in order to protect your confidentiality, all digitally recorded data will be transcribed by myself and the transcribed data will be identified only by code number and securely stored in a password protected computer which would only be accessible to myself and my Thesis supervisor. All hard copies of the data (i.e., transcribed interview, informed consent form) will be stored securely in my Thesis supervisor's office in a lock protected file cabinet within the Department of Sociology at the University of Manitoba.

You will not be named or identifiable in any reports of this study (i.e., statements you make will be attributed to an anonymous source identified with a pseudonym). Any potentially identifying information in interview transcripts will be removed at the time of transcription (rendering it confidential) such as names of physicians, staffs, and clinics in order to protect your identity as well as the health care institution and provider's identity. Other information pertaining personal identifiers (e.g., consent forms, audio files) will be destroyed as soon as it is no longer necessary for scientific purposes (i.e., approximately August 2017). Electronic and hard copies of interview transcripts will also be deleted and/or shredded after the completion of the project (i.e., approximately August of 2017).

Dissemination:

This research is in partial fulfilment of the requirement for Masters of Arts degree in Sociology. However, the information obtained in this research may appear in academic journals and other research publications (or conference presentations). Again, your personal confidentiality will be maintained throughout.

Feedback to Participants:

A brief (1-3 pages) summary of the research findings or results will be provided to all interested participants by December of 2016 (see below).

Risks and Benefits:

There is the possibility that you may experience some form of emotional upset or distress when asked to reflect on past health care experiences due to some form of traumatic experiences. In such a situation, I can help you to identify appropriate mental health services if you would like these – such as drop-in counselling (Klinic Community Health, 545 Broadway or 845 Regent Avenue West, Winnipeg). It is important to know that you do not have to answer any question that you do not want to, and you can stop the interview at any time. In terms of benefits, research findings can identify possible areas of improvement in the Canadian health care system which could eventually improve the future health care experiences of immigrants. Also, you might find it empowering to share their view and experiences on this topic.

Consent:

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in this research project and agree to participate. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Psychology/Sociology Research Ethics Board at the University of Manitoba. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at humanethics@umanitoba.ca, or 204-474-7122. A copy of this consent form will be given to you to keep for your records and reference.

Research data that contain your identity and any health-related information you share with me will be treated as confidential in accordance with the Personal Health Information Act of Manitoba. All records will be kept in a locked secure area and only those persons identified as requiring access to your records will have opportunity to review or copy these data.

If you agree to each of the following, please place a check mark in the corresponding box. If you do not agree, leave the box blank:

I have **read or had read to me** the details of this consent form. [ ]

My **questions** have been addressed. [ ]

I, _____ (print name) **agree to participate** in this study. [ ]

I agree to have the interview **audio-recorded**. [ ]

I agree to have the findings (which may include quotations) from this project **published or presented** in a manner that does not reveal my identity. [ ]

Do you wish to receive a **summary** of the findings? [ ] Yes [ ] No

I would like to receive the summary of findings by: [ ] E-mail [ ] Mail

Mailing Address: _____

_____

Participant's Signature: _____ **Date:** _____

Researcher's Signature: _____ **Date:** _____

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Appendix III

Dear Organizational Director, Name and Address

My name is Efe .O Ehigiato and I am a graduate student in the Department of Sociology at the University of Manitoba. I am contacting your organization to request your help in promoting a study I am conducting on Nigerian immigrants' experiences in accessing and receiving health care services (part of my Master's Thesis).

Study Title: Nigerian Immigrants' Experiences in Accessing and Receiving Health Care Services in Canada

Principal Investigator: Efe Oghogho Ehigiato

ehigiate@myumanitoba.ca.

Thesis Supervisor: Dr Laura Funk,

Associate Professor, Department of Sociology

204-474-6678/ LauraFunk@umanitoba.ca.

For this study, I am interested in talking to Nigerian immigrants about their experiences in gaining access to and receiving health care services in Canada. Interviews will require approximately 1-1.5 hours and will be conducted either at the University of Manitoba or a more convenient (and quiet) location for the participant. Participants will receive a $10.00 grocery gift card in consideration of the expenses they incur related to their participation and to express appreciation for their time and participation.

I would like to request your organization's help in identifying potential interested participants by distributing the attached information sheet about the study to your members through posting it in your newsletter(s). I will provide your organization with a brief written summary of the study results once the research has concluded.

This research has been approved by the Psychology/Sociology Research Ethics Board. If you have questions or concerns about this research you may contact myself or my thesis supervisor at the contact information listed above; you may also contact the Human Ethics Secretariat at 474-7122, or email humanethics@umanitoba.ca. Please accept my sincere appreciation for your contribution in promoting my study.

Efe O. Ehigiato,

Graduate Student, Department of Sociology, University of Manitoba.

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Appendix IV

Study Participants Needed:

Nigerian Immigrants' Experiences Accessing and Receiving Health Care Services in Canada

- Did you emigrate from Nigeria to Canada?
- Are you 18 years of age or older?
- Have you lived in Canada for 5 years or less?
- Have you ever visited any health care institution or professional in Canada for treatment of a chronic or acute condition?

- **Efe O. Ehigiato, a graduate student in the Department of Sociology is conducting interviews with Nigerian immigrants about their experiences with the health care system in Canada.**
- **Interviews will take about 1 to 1.5 hours of your time and will be conducted at a quiet and mutually suitable location.**
- **Interviews involve talking about your experiences with the Canadian health care system, including seeking health care services here.**
- **Study participants will receive a $10.00 grocery gift card.**

Interested participants should contact:
Efe O. Ehigiato at ehigiate@myumanitoba.ca

***This study has been approved by the Psychology/Sociology Research Ethics Board**
If you have any questions or concerns, please feel free to contact either myself or my supervisor: Dr. Laura Funk: Laura.Funk@umanitoba.ca.

Appendix V

UNIVERSITY of MANITOBA

Research Ethics and Compliance
Office of the Vice-President (Research and International)

Human Ethics
208-194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Phone (204) 474-7122
Fax (204) 474-7123

APPROVAL CERTIFICATE

May 11, 2016

TO: **Ehigiato Efe Oghogho** **(Supervisor: Laura Funk)**
Principal Investigators

FROM: **Kelley Main, Chair**
Psychology/Sociology Research Ethics Board (PSREB)

Re: **Protocol #P2016:059 (HS19697)**
"Nigerian Immigrants' Experiences Accessing and Receiving Health Care Services in Canada"

Please be advised that your above-referenced protocol has received human ethics approval by the **Psychology/Sociology Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). It is the researcher's responsibility to comply with any copyright requirements. **This approval is valid for one year only and will expire on May 11, 2017.**

Any changes to the protocol and/or informed consent form should be reported to the Human Ethics Coordinator in advance of implementation of such changes.

Please note:

- **If you have funds pending human ethics approval, please mail/e-mail/fax (261-0325) a copy of this Approval (identifying the related UM Project Number) to the Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM Project Number: http://umanitoba.ca/research/ors/mrt-faq.html#pr0)**

- **If you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) in order to be in compliance with Tri-Council Guidelines.

umanitoba.ca/research