ESL-Speaking Immigrant Women’s Disillusions: 
Voices of Health Care in Canada: 
An Ethnodrama

LAURA E. NIMMON
University of Victoria, Victoria, British Columbia, Canada

This article describes a research project that investigated whether language barriers play a part in immigrant women’s health decreasing when they move to Canada. The findings are then represented in the form of an ethnodrama entitled “ESL-Speaking Immigrant Women’s Disillusions: Voices of Health Care in Canada.” I suggest that the play is catalytic because it encourages target audiences to empathize with the silenced voices of ESL-speaking immigrant women who live in Canada. I then conclude with a reflection about the potential that the genre of ethnodrama has for social change through its reflexive and critical nature.

According to the Canadian Institute for Health Information (CIHI, 2004) ESL-speaking immigrant women’s health decreases when they move to Canada and despite Canada’s public health care system, language barriers may prevent immigrants from accessing it. The compelling nature of this claim lead me to embark on a pilot study that aimed to identify some of the reasons immigrant women’s health decreases when they move to Canada and to see if, in fact, these women do experience linguistic barriers when trying to access health information. The results of my study are presented in the form of an ethnodrama, which engages the audience in a process that involves critical reflection and empathy about real-life situations that often are silenced within the respective culture.

REVIEW OF THE LITERATURE

Today, literacy is defined as being able to “read, write, speak proficiently, to compute and solve problems, and to use technology in order to become

Received 23 January 2006; accepted 31 May 2006.
Address correspondence to Laura Nimmon, 1146 St. David Street, Victoria, BC, V85 4Y9, Canada. E-mail: LN@uvic.ca
a life long learner and to be effective in the family, in the workplace and in the community" (Roman, 2004). Recently, however, the definition of literacy has expanded to include what is called health literacy.

The term health literacy is defined as “the ability to read and comprehend prescription bottles, appointment slips, and other essential health related materials or the capacity to obtain, interpret and understand basic health information and services needed to make appropriate health decisions” (Dowe, Lawrence, Carlson, & Keyserling, 1997; Roman, 2004). People with inadequate health literacy skills often have difficulty understanding diagnosis, discharge instructions, and treatment recommendations. Some researchers believe that this is because pamphlets and other written materials often require at least a ninth-grade reading comprehension level (Wilson, 2003). Most interestingly, however, some researchers have noted that the ability to read is not an indicator of functional health literacy because studies have found that a third of patients with postsecondary education were unable to understand health information (Pirisi, 2000). Some hypothesize that the reason patients are not health literate, despite levels of education, is because they are not well versed in common medical terminology used by health care professionals (Pirisi, 2000).

In short, inadequate health literacy directly affects patients’ abilities to follow instructions from physicians, take medication, understand disease-related information, learn about disease prevention and self-management, and understand their rights. Health illiteracy also affects patients’ abilities to access care, in particular because of difficulties completing application forms. Most significantly, however, it increases the chances of dying of chronic and communicable diseases (Wilson, 2003). In short, health literacy has emerged as a critical component of functional literacy, with possibly the most severe consequences for both the individual, and society.

My study was an inquiry into the CIHI (2004) hypothesis that suggests that immigrant women’s health decreases because they may face language barriers that prevent them from accessing our public health care system. Although this was the main focus of my research, I also asked the participants questions about their experiences of immigrating to Canada and other factors they have noticed that may have affected their health upon migrating here. To create a background for my inquiry, I looked at studies that show how social, economic, and political forces also play a crucial role in determining the subjective health experiences of immigrant women (Anderson, 1985). Also, I reviewed research that illustrated that immigrant women experience a decrease in health because of changes in traditional values and lack of social support when they move here (Choudry, 2001; Macleod & Shin, 1990). Furthermore, I reviewed studies that show that immigrant women’s inability to communicate well in English and feelings of helplessness create a sense of psychological isolation that leaves them with a devalued sense of self (Franks & Faux, 1990; Guo, 2004; Mulvihill & Mailloux, 2001).
In summary, the literature states that language barriers and difficulties with the acculturation process (the process of coming to know a new culture) can have long-term effects on ESL-speaking immigrant women’s health status (Brown, 2000). Thus, I looked primarily at the implications that a lack of language skills may have on immigrant women’s access to health care, but I also took into account the above research that informs us about the dynamic interplay of factors that affect an immigrant women’s health status after immigrating to Canada, which surfaced in the interviews.

AN ETHNODRAMA

What Is an Ethnodrama?

As Conrad (2004) puts it, “What better way to study lived experience than to re-enact it” (p. 3). The ethnodrama is probably best defined by its goal for personal reflexivity and social awareness, as well as by the form of representation it embodies. Encompassing postmodern values, the genre of ethnodrama creates a space where multiple perspectives are activated and where truth becomes subjective and interpretive. According to Pifer (1999), “There is not one interpretation of the ethnographic text; there are many. Just as there is not one voice within it, there cannot be one single interpretation” (p. 559). The ethnodrama thus challenges fixed representations of research subjects (Goldstein, 2001). According to Freire (1970), “In problem-posing education, people develop their power to perceive critically the way they exist in the world with which and in which they find themselves; they come to see the world not as a static reality, but as a reality in process, in transformation” (p. 83). This genre of research also aims for “conscientization” (Freire, 1970) because it helps the audience, participants, and the researcher think critically about their world. Essentially, due to its critical and reflexive nature, ethnodrama, as a form of representing reality, is a way of acting on the world in order to change it.

Key Assumptions

The ethnodramatic researcher believes that we claim knowledge in a subjective interpretive and interactive way. For example, in the act of creating a play out of data from an interview, there is reaffirmation of the participant’s voices by the researcher; illustrating the interactional nature of the interview. Furthermore, there is an interactive nature to the genre itself that is through the transformative and catalytic inner dialoguing that exists between the audience, the participants, and the researcher (the latter two usually are part of the cast). According to Sparkes (2002) the ethnodrama has advantages...
over purely textual reports in terms of validity because it remains true to lived reality. Perhaps the ethnodrama may not be an exact rendition of lived reality; however, it is most certainly a powerful translation of lived experience. In fact, according to Pifer (1999), through performance the lives, voices, and events presented will have a life and power not possible through other forms of presentation.

The General Process for Creating This Genre

Ethnodrama is created by transforming data and analysis based on interviews, observations, participant observations, and diaries into theatrical scripts and performance pieces. Some researchers draw on the works of philosophers and scholars and include that perspective in their pieces. For example, Pifer (1999) constructed his script based on some autobiographical reflections and the writing and works of various academics. Other researchers have revamped their play based on the feedback they received from audiences. For example, Goldstein (2001) noted that she has given a number of different performances to different audiences because the feedback from all of them informed the writing of the play.

When an ethnodrama is written and preformed well, it reminds us that truth is interpretive and subjective because it does not permit the static representation of subjects often seen in other forms of research. Truth is portrayed within the dynamic characters in the play and is determined differently by each member of the audience, thus reaffirming that an ethnodramatic researcher adheres to the belief that truth is subjective.

Why I Chose to do an Ethnodrama

The type of data from my study suggests interpretations as an ethnodrama because it is representative of voices that often are marginalized in our society. I wanted to give voice to the lived reality of the immigrant women I interviewed. Ethnodrama is very conducive to this purpose because it takes the actual language of the participants and transfers it into a play. Therefore, the language that the participants used will not be lost. According to Burke (1997) the validity of qualitative research refers to accurately portraying the meaning attached by the participants to what is being studied by the researcher. More specifically, he notes that it refers to the degree to which the research participants' viewpoints, thoughts, feelings, intentions, and experiences are accurately understood by the qualitative researcher and portrayed in the research report. Burke suggests using the participants' actual language and dialect, so that the reader can get further into the mind of the participants, which is what I did.
METHODOLOGY

Collecting the Data

The data was collected from 5 ESL-speaking immigrant women. Two of the women were seniors (one originally from Mexico and one originally from China) and both had been living in Canada for more than 20 years. Another woman in her late twenties was originally from Brazil and had been living in Canada for 5 years. Another woman was middle aged and came from Chile and had been living here for 10 years. The last woman I interviewed was a 50-year-old woman originally from Japan; she had been living here for 8 years. All of the women I interviewed spoke about a low-to-intermediate level of English. I interviewed each of the women individually and asked them about their experiences of health in Canada. My main research question was, “Do language barriers play a part in immigrant women’s decrease in health after moving to Canada?” Thus, the questions I asked them follow: (a) Did you have any language problems accessing health care here, (b) Did you know how to access health care, (c) Did you have knowledge about Canadian health resources, (d) What experiences did you have with your health after moving here, (e) Does the CIHI (2004) statistic make sense to you and why? (e) Did you feel isolated when you first moved here? (f) How well did you speak English? (g) Were you healthier in your country of origin and why? and (h) Have you noticed any unhealthy behaviors in Canadian people that has surprised you? I tape recorded the interviews and then transcribed them. I then analyzed the data and represented the women’s experiences of health to an academic audience in the genre of ethnodrama.

Analysis

For my analysis I began by reading over the transcripts of the interviews that I did with the women. I looked for main themes and circled what I thought were the most important elements of the data (DeNardo & Levers, 2002). Then I used the NVivo software to filter the data by selecting nodes, which are phrases out of the text that are significant to the study. An example of a node was, “depression due to not knowing the language.” I then found four phrases to fit this node within the text, which all expressed feelings of depression because of the lack of language skills. The phrases for this node follow: (a) “I felt really depressed when I first moved here because I couldn’t speak English.” (b) “When my partner moved here he was really depressed for some time. He couldn’t speak English well and I think he was more depressed than me.” (c) “Now looking back on it if I had seen my doctor during that time he would have said I was really depressed and that I needed treatment.” (d) I couldn’t understand why I felt so depressed. I would cry all day and then I would take a shower when I knew my homestay family
was about to come home. Then I would sit down for dinner and pretend everything was okay."

After I had selected all of the nodes, I then grouped them into trees based on themes. I came up with six trees or themes pertinent to my study and placed the nodes under the relevant trees. The tree titles I chose were (a) problems with low-level English, (b) unhealthy diets in Canada, (c) reactions to health care in Canada, (d) challenges to the CIHI (2004) finding, (e) other factors affecting health, and (f) cross-cultural differences related to health. I then created a map where I could see, visually, the six main themes and the nodes that I grouped under the trees. There were two "outlier nodes" that did not fit into any trees, and these were "family-sponsored immigrants" and "good quality of life." I let these "outlier nodes" float on the map, but I attached them by an arrow to the trees that I thought they might connect to most. Thus, I attached the outlier "family-sponsored immigrants" to the tree "other factors affecting health" and I attached the other outlier, "good quality of life," to the tree "challenges to the CIHI (2004) statistic." Finally, after reflecting upon the main themes from my study, and the text within it, I created an ethnodrama to represent the data.

How I Created My Ethnodrama

My process of creating an ethnodrama involved several components. The first was to look at the transcripts for overall themes or scenarios described that might be appropriate to turn into a scene in a dramatic piece. For example, one woman spoke about her difficulties using the phone to call a health center to talk to a nurse. So, I thought this real-life scenario would be effective to act out in front of my audience (Act 3). Another example of a scene is Act 2, where I created a scenario where I could combine the nodes from the tree "unhealthy diets in Canada" to convey the women's reactions to the cost of expensive food verses unhealthy food in Canada and also their comments about the amount of obesity in Canada and the consumption of fast food. I, thus, looked at my NVivo map and created four scenes based on the trees that emerged from the data. I also looked into the interview verbatim within the tree’s nodes and transferred them to the dialogue in the play. I even tried to include some grammatical or vocabulary mistakes that the women made in order to keep the play as realistic as possible. I later decided to soften these mistakes because I did not want to come across as disrespectful in the portrayal of the women’s voices.

I then began each act by inserting a few sentences about the scene and I wrote up the script. At the end of each act, I inserted the words of a theorist to give some background research and a critical perspective pertaining to the scene. I then showed the play to the participants who had provided me with the original data, and I edited the play based on
their suggestions. For example, I again took out some of the more explicit spelling mistakes, as one participant thought it would interfere with the overall reading of the ethnodrama. I then participated in acting out the final script in front of an academic audience, which included some health care workers, and involved the members of the audience in the reading of the play because I believed this would help them feel the experiences of the participants.

Afterward, I asked everyone what they thought about the play. I was amazed to hear how much the audience said they learned and how the play will resonate with them for a long time. In fact, one audience member, who works with ESL speakers, pointed out that she would now be much more sensitive to ESL speakers who call her at work. So, that comment, in itself, made me think about the catalytic power of an ethnodrama, “which more conventional forms of reporting are not seen as capable of accomplishing” (Sparkes, 2002, p. 129).

A member of the audience also suggested that I should add some judgmental inner thoughts of the Canadian nurse toward the ESL speaker when the ESL speaker calls in Act 2. I have, thus, subsequently readapted the play, since the whole idea of an ethnodrama is to rewrite the script based on the audience’s feedback. I only added one line because I believe that an ethnodrama is very subtle by nature. In addition, I would not want to insult or turn off health care workers by assuming that they are all judgmental toward ESL speakers. Thus, in this play, the judgmental thoughts of the nurse are meant to help some health care professionals see their impatience in a new way. In short, I believe my ethnodrama “ESL-Speaking Immigrant Women’s Disillusions: Voices of Health Care in Canada” was effective because it stimulated feelings of empathy that created a new awareness within the audience.

AN ETHNODRAMATIC REPRESENTATION
ESL-SPEAKING IMMIGRANT WOMEN’S DISILLUSIONS:
VOICES OF HEALTH CARE IN CANADA

Act 1

PROBLEMS WITH LOW-LEVEL ENGLISH

(Maria has just moved here from Brazil and is staying with a Canadian family. She has just started her Master’s in Canada. She is talking in Portuguese on the phone with her boyfriend in Brazil.)

Maria: ... Well, I knew it wouldn’t be easy.

Jose: Are you able to talk to the people you are staying with?

Maria: Yes, they are very nice, but I haven’t shown them how I really feel. And I am afraid to talk to them about anything in detail because of my poor language skills.
Jose: But you studied so much before you left. You were in the highest level of English classes and you were one of the top students.

Maria: (holding back tears) I know, I thought I would come here and be able to talk to everyone. But everybody here talks sooo fast and a lot of the vocabulary I just don’t know. I met a girl at the meeting I had at the university today and she moved here from Colombia 6 years ago and she says that she still doesn’t have the same vocabulary that she has in Spanish. I feel like I should come home. I am not feeling well.

Jose: Have you been eating well Maria? What have you eaten today?

Maria: Ummm... oh my gosh... You know its 7 pm and I haven’t eaten anything all day.

Jose: You need to eat more Maria. That is probably why you are feeling down.

Maria: I think you are right. I feel like so weak for not being able to cope here. And I should just be happy with this opportunity. I can’t believe I haven’t been eating. I have just been crying all day. Oh... I have to go. They are home now.

Homestay mother: Hi Maria! How was your day today? What did you do?

Maria: Oh, it was wonderful. I had nice day at the university....

Theorist: Many researchers have written about how depression is a typical reaction to immigrating to a new country (Fanks & Faux, 1990; Guo, 2004; Mulvihill & Mailloux, 2001). Often people don’t have the language skills, confidence, or resources to get help. They may not have anybody to talk to about their feelings, and studies show that immigrant women’s inability to communicate well in English and feelings of helplessness create a sense of psychological isolation, which often leaves immigrant women with a devalued sense of self.

Act 2

Unhealthy diets in Canada

(Monica is an immigrant from Mexico and has lived here for many years. She has just come home from visiting family in Mexico and is shopping at Thrifties with her Canadian friend Lisa.)

Lisa: It’s really tough times right now for Jake and me. We have to live paycheck to paycheck since he got laid off from his job.

Monica: That’s hard, isn’t it?

Lisa: Yeah. Hey, how was your trip to Mexico to visit your family? It looks like you lost some weight. Must have been all the time in the sunshine?

Monica: Actually, it wasn’t all that sunny. But in Mexico we don’t really have the fast food, so I wasn’t eating any fries and hamburgers. And the fitness places aren’t as expensive in Mexico, so I went to the gym.
Lisa: Really... hmmmm... I can’t believe nobody eats fast food there.
Monica: Well, there is McDonald’s, but it is so expensive that nobody
goes there. I try not to eat the fast food here, but it’s huge! In Mexico, we eat
mostly vegetables, rice, and beans... you know. We have the big lunch in
Mexico because it’s the most important meal of the day. So, I am not eating
a big meal and then going to sleep.
Lisa: You should make me a Mexican meal sometimes.
Monica: Well, actually it’s really hard to get the ingredients here. I have
looked, but a lot of it I haven’t been able to find. And the Mexican foods that
are here have a lot of preservatives... I mean preservatives. A lot of food
here does. Hey, what are you doing tonight?
Lisa: Well, its Sally’s birthday, so we are going to Burger King. You
know, we just really can't afford to go anywhere else as a family for dinner.
Monica: I know. That is where we go to when we go out for the dinner.
It’s so much cheaper than eating anywheres else and we can afford to take
the whole family to a restaurant.
Lisa: Well, let’s get going. Do you have all of your groceries?
Monica: I just need to get some beverages. Hmmmm... (looking at the
choices of drinks to buy)... Well, there is this real juice for 4 dollars, or there
is the drink, which isn’t real juice, and it’s only 3 dollars. I guess I’ll get the
3 dollar one... Alright... sorry for taking so long. Let’s go!
Theorist: A lot of immigrant women comment about the poor
nutritional habits of Canadians, remarking that our nutrition is shocking and
that they are surprised at how expensive health food is here compared with
unhealthy food. The women I interviewed also mentioned how overweight
people are in Canada compared with their previous countries.

Act 3

RESPONSES TO HEALTH CARE IN CANADA

(Monica is having an allergic reaction to something and she has red bumps
all over her body. She tries calling a health center in Victoria and gets a
recorded message on the answering machine.)

Machine (speaking quite fast): You have reached the Victoria Medical
Clinic. I am sorry we are not available to take your call. We are open from
Monday to Friday from 9 am to 3 pm. If this is an emergency, please contact
this number at 351-5565 where somebody will respond to your call.
(Monica dials again because she can’t understand the message. Monica
is starting to panic. She dials twice more and on the fourth time she finally
understands the message. Monica calls the number and speaks with a nurse.)
Monica: Hi, ummm. . .
Nurse: Please speak up dear, I can’t hear you.
Monica: Hi, um. . . ummm. Well, I am really scratchy.
Nurse: Scratchy? What do you mean? You mean itchy?
Monica: Yes, ummm, itchy. I have little points all over my arm…. I mean little dots. They are red…..red.
Nurse: (It is sooo annoying when ESL speakers call here.) Oh, you mean you have a rash. It’s a rash.
Monica: (This is incredibly embarrassing, I feel like a child.) Yes, a rash. I am sorry. It’s so uncomfortable. What should I do?
Nurse: You should go and see a doctor.
Monica: You mean a specialist?
Nurse: Well, you have to go to a general practitioner first. And then you’ll get a referral to see a specialist.
Monica: You mean I can’t just go to a specialist on my own? I know what is wrong with me….I need to see a dermatologist.
(Later in the week: After seeing the doctor Monica is at the pharmacist picking up her prescription.)
Pharmacist: So, you just need to take 2 of these for 3 weeks at bedtime.
(Monica takes the prescription without listening. She doesn’t need to listen to the pharmacist because in Mexico she often self-medicated and decided how many pills she thought she should be taking.)
Theorist: Cross-cultural differences in health care arise for immigrant women when they are dealing with the health care system here. Some women have mentioned that in their countries they would go straight to a specialist for medical care and that they are more in control of the amounts of medication they would take. They felt they had more autonomy and choice over their health. Also, research shows that ESL speakers have difficulty understanding health care information when it is delivered only orally. This means that any discussion about health should be done with visual tools as well (Finan, 2002). The scene with Monica phoning the nurse helps explain the CIHI (2004) research that states that immigrant women may have trouble accessing our health care system because of language barriers.

Act 4

Other factors affecting health

(Maria has now been living in Canada for 6 years. Her boyfriend moved here to be with her from Brazil and now they are married. It’s Easter Sunday and they are talking over dinner.)

Maria: I wonder what Mama and Papa are doing for Easter.
Jose: Probably the usual. Going to church and then having the whole family over for dinner. I bet there will be a lot of dancing.
Maria: (Sigh) I really miss it there sometimes. I can’t believe how many people here don’t go to church. I mean, most of our neighbors have been at home today and I haven’t even seen any of their family go over there for dinner. People spend a lot of time on their own here.
Jose: I know. But we have so much opportunity here.
Maria: I know. Everyone at home thinks we are so lucky to be here. But I just don’t feel totally integrated and we’ve been here for 6 years. I miss our families and the community we had in Brazil. People were always out on the streets and there is always music playing. It’s starting to wear on me.

Jose: It’s funny . . . before we left we had a lot of money. We had maids and our parents put us through the best private schools. Even to be able to come here we had to be in perfect health and show we had a lot of money. Now, we struggle to have full-time work even though I was a dentist in Brazil. I still have barriers because of my language level, and I have not been accepted yet as an immigrant and my papers for dentistry not recognized yet. It just hasn’t been very easy. I feel we have stepped down in social class . . . really.

Maria: Maybe we should go back. But we have too much pride . . . and I love Canada. It’s just going to take time, Jose. I think maybe we were happier in Brazil, but it is just going to take time here. It’s the land of opportunity.

Jose: I guess we often feel lonely . . . you know . . . maybe even a bit depressed. I think a lot of it is missing family and friends . . . . I didn’t expect we’d feel this way. And I don’t want to complain.

Theorist: When immigrant women move here their health is usually very good. Over the years, however, it decreases. Although language barriers to accessing health care may be a component of this, there are also other reasons. For example, research says that their health can decrease because of changes in social support and in traditional values (Choudry, 2001; Macleod & Shin, 1990). This was mentioned by the women that I interviewed also.

LIMITATIONS

Study Limitations

This study had limitations. The first limitation was the limited number of participants in the study. The personal nature of the interviews, however, only permitted me to interview women that already trusted me and would, thus, confide in me. Another limitation that arose was that the women responded defensively when I told them about the CIHI (2004) statistic that states that immigrant women’s health decreases when they move here. I believe that the purpose of research is to create empowerment and critical thinking about one’s reality. Thus, even though some of the women denied the statistic, I wondered at the time if perhaps they would take a moment to reflect critically on the conversations we had about their experience of health in Canada. Most interestingly, after some of them read the play, they revealed to me much more about their experiences pertaining to their health decreasing since they moved to Canada, perhaps knowing that they were not alone in the feelings they had living here or perhaps because the play triggered some more of their own experiences.
Limitations of the Ethnodrama

A well-done ethnodrama persuades the audience to have empathy for the characters and to think critically about the situation represented. For example, after viewing Gray’s (2000) play some audience members commented, “They had never considered what it would be like for ill people to receive mountains of unsolicited advice from friends and family on beating cancer” (p. 387). A poorly done ethnodrama may turn people away from the very messages it tries to portray. A well-done ethnodrama, however, is meant to stir the audience emotionally, so that there will be compassion, empathy, and new understandings for the characters’ lives and also to prompt critical thinking about the social and lived realities presented. Being able to think critically and have empathy for individual and social realities helps “develop consciousness and mobilization for action” in audience members (Conrad, 2004, p. 4). For a human being to become fully human they need to be able to think critically about reality because reality has a fluid nature and is constantly in transition (Friere, 1970). Social transformation and emancipation is the ultimate goal of an ethnodrama, so if critical thinking occurs in audience members, then the ethnodrama is considered a success.

CONCLUSION AND IMPLICATIONS

There needs to be more research done regarding the predicament that ESL-speaking immigrant women face regarding their health when they move here. According to my findings, the CIHI (2004) hypothesis that language barriers affect women’s abilities to access health care is correct. The women I spoke to both gave examples of how language barriers have, in fact, impeded on their ability to access health care here. For example, consider the scene in Act 3 of the play when Monica has trouble communicating her medical problem to the nurse: “I have little points all over my arm. . . . I mean little dots. They are rad. . . . no. . . . red.” Furthermore, these women also mentioned that after studying English in their previous countries or even after many years living here, their English language skills are still not up to par with the majority of Canadian native English speakers. The dilemma of women moving here and then realizing their English is not as fluent as Canadian native English speakers is represented in Act 1 in the scene where Maria is talking to her boyfriend in Brazil: “. . . I haven’t shown them how I really feel. And I am afraid to talk to them about anything in detail because of my poor language skills.”

My own assumptions were also correct, in hypothesizing that immigrant women’s health decreases for various multifaceted reasons that encompass both language barriers and other components. For example, in their interviews the ESL-speaking immigrant women also mentioned some emotional, economic, and social factors that have affected their health. Emotional factors
are show in Act 1 when Maria’s boyfriend asks her if she has been eating well and she says “I can’t believe I haven’t been eating. I have just been crying all day.” Also, an example of economic factors that affect health is shown in Act 2 when Monica chooses an unhealthy beverage and justifies it by saying, “There is this real juice for 4 dollars, or there is the drink, which isn’t real juice, and it’s only 3 dollars. I guess I’ll get the 3 dollar one.” Finally, an example of social factors affecting health is illustrated in Act 4 when Maria and Jose are alone for Easter and Maria says, “Everyone at home thinks we are so lucky to be here. But I just don’t feel totally integrated and we’ve been here for 6 years. I miss our families and the community we had in Brazil… It’s starting to wear on me.”

The dramatic representation of these women’s experiences of their health in Canada gives voice to lived realities that are most often overlooked within our society. For example, Boyd (1991) claims that while literacy rates for Canadian adult men and women are comparable, immigrant women have lower literacy rates on average. Simms (2003) also notes that the inability of large numbers of Canadian immigrant and refugee women to speak English well is a major obstacle to accessing services like health care. This situation within Canada does not seem likely to improve anytime soon. For example, the February 2005 Association of B.C. Teachers of English as an Additional Language (BC TEAL; Kozakiewicz, 2005) newsletter included an article about how changes in the provincial funding model have created some serious limitations in the English Language Services for Adults (ELSA) program. The lack of services for immigrant people in the province of BC is of grave concern, as well as the fact that childcare funded by the ministry for mothers who attend ELSA classes have been reduced, which Kozakiewicz notes “places even more of a burden on the already marginalized population of immigrant and refugee mothers” (p. 5).

Immigrant women are especially marginalized because when they come to Canada they often experience “linguistic and cultural isolation, changes in occupation and vocation, intergenerational conflict, culture shock, the unavailability of supportive relationships and the inversion of traditional family roles (Macleod & Shin, 1990). Coupling this dilemma are findings released in March 2005 by a Statistics Canada report that states that 12 years from now, Canada’s immigrant numbers are expected to have grown significantly and will reach between 7.0 million and 9.3 million in 2017 and will account for 22% of the population.

It is anticipated that immigrant women will represent a fairly significant proportion of the Canadian population in the future and, thus, there must be more sensitivity toward and awareness of this vulnerable population of Canadians. One result that the ethnodrama “ESL-Speaking Immigrant Women’s Disillusions: Voices of Health Care in Canada” could have is to create social change because it invites people to feel empathy for the immigrant characters portrayed. This form of engagement may have
some profound implications in terms of creating transformative and catalytic awareness within the audience by having the audience understand these women's experiences in a new and compassionate way or, perhaps, for the very first time. An ideal situation in which to present this play could be at an in-service workshop for health care practitioners who work with a second-language immigrant population. For example, the situation in Act 3 where Monica is trying to communicate with the nurse about her health problem and the nurse is feeling frustrated is subtle but powerful. If a student in my class came up and genuinely said to me, “I will now be much more sensitive to ESL speakers who phone my work,” then it is easy to see the implications of presenting this play in a setting where there are various health care workers or health professionals who work daily amongst a second-language-speaking immigrant population. The form of the ethnodrama, however, can reach various audiences who work with or study specific populations within the health care setting. The possibilities are many in the open-ended dialogue that ethnodrama fosters.

I hope that this play strengthens a voice that is often overlooked within government policy, which is that of immigrant women. I also hope that it gives some insight to health professionals, scholars, students, and health education specialists about the complex and multifaceted experiences of health that ESL-speaking immigrant women have when they move to Canada. As a nation that prides itself as tolerant and accepting, Canadians have to walk the talk to become a truly healthy multicultural nation. This means creating research that is dedicated to presenting and exploring the lived realities of a silenced population within Canada. The ethnodrama has the capability to express these silenced voices in any country to various audiences in a way that evokes not just understanding, but also empathy.

CLOSING THOUGHTS

An ethnodrama can create an opportunity to promote critical reflection and empathy about real-life situations that often are silenced. It provides an outlet for audience members to discuss the possibilities of transforming the oppressive elements of the experience of others, culminating in collective social action. This involves a dynamic form of reflection and action or praxis and ultimately is linked to the concept central to Freire's participatory processes: “only those who listen, speak” (Freire, Fraser, Macedo, McKinnon, & Stokes 1997, p. 306).

REFERENCES


