Bhooma Bhayana, 2018. Online Supplement e4. Sara Is Not Her Real Name. Arya & Piggott. Under-Served Book. (underserved.ca)

Sara is Not Her Real Name

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LEARNING OBJECTIVES

After reading this chapter, you should be able to:

Sara is not her real name. She came to see me many years ago on the referral of her best friend who is a long time patient. Sara was then pregnant with her fourth child. She was born in that romantic land between the North Western Frontier of Pakistan and Afghanistan, a land of rugged terrain and rugged machismo. Sara had spent time in a refugee camp of sorts in Peshawar before applying for refugee status in Canada. She and her family cherished the opportunity to transition from being stateless to becoming Canadian.

Sara's English was limited and her friend thought that my pidgin second generation Hindi and her mix of Pashto Urdu might make for some passable communication.

Sara had been in Canada for four years before I met her. We met several times to do the perfunctory prenatal care regimen. Every visit, her eyes would be downcast, her voice a barely audible whisper. I attributed this to cultural norms and deference to the authority of a physician. It is said that when women speak of the high price of rice, they are really speaking of the ingratitude of children and the indifference of their husbands. Our pre and post appointment banter moved on to talk of South Asian fashion and food. By the fifth visit, she began to meet my gaze and speak of her home life. Her marriage was arranged when she was 13 and she accepted it as a norm. There had been some physical abuse in Afghanistan but it escalated when her family arrived in Canada. Her husband's own isolation, his inability to find work and overall sense of disempowerment contributed to his pervasive anger. She was the most accessible target.

By the tenth visit, we broached the idea of leaving the relationship. It is difficult for any woman to leave an abusive situation. However, for a woman new to the country and facing the possibility of deportation, safety planning seemed almost insurmountable. Her separation would also have implications for the honour of her parents and brothers "back home" in that rugged land of machismo. And so, Sara remained in that relationship. Emergency room reports would trickle into my office about a fall here, a bumping into a wall there. Sara liked to think that the children were unaware of the abuse. Yet, she saw in the way they hit one another in play that they were aware of everything. Finally, a kind imam gave her permission to leave and his sanctioning of the separation saved the family honour.

I am reminded of Miranda Davies' book, *Third World- Second Sex* (1983). The Saras in my practice need another book for them entitled, *Third World, Second Sex- Displaced*. I could have related stories from my practice of young women who went for a summer vacation with their families to North Africa and returned circumcised or the stories of women who have been threatened by honour killings by enraged brothers and fathers. Sara's story is not ghoulish or sensational. It is not unlike the stories of many women facing domestic violence in my practice who are not immigrants or refugees. The context and forces at play are different and the approach must, therefore, differ as well.

Kofi Annan has called violence against women the most pervasive, yet least recognized, human rights abuse in the world. A study of Canadian women exposed to Intimate Partner Violence (IPV) looked at national population based data on 6859 women who reported physical and sexual violence in their relationships. Both Canadian born and immigrant women reported similar consequences of IPV but immigrant women were more likely to mistrust neighbors, friends and authorities. They were more likely to report isolation based on language barriers and discrimination (Du Mont and Forte 2012).

Sara faces disparate health outcomes in many other arenas as well. Immigrant and refugee women are less likely to be screened for certain cancers including breast, colon and cervical cancer. They are also less likely to be screened for chronic diseases such as hyperlipidemia and diabetes. If they are diagnosed with breast cancer, they are less likely to be offered immediate breast reconstruction. The literature points to many inequitable health outcomes for Sara (Borkhoff 2013; Kliewer 2005; Torres 2013)

Perceiving greater barriers in accessing contraceptive choices, Sara is less likely to use hormonal contraceptive options (Torres 2013).

Perinatal outcomes in the developing world are poor. Sadly, the literature points to disparate perinatal outcomes for women who are refugees and immigrants from resource poor countries in the developed world. A 2015 study found that all cause maternal morbidity is higher in immigrant women from sub Saharan Africa in Canada and Australia (Urquia 2015). In particular, pre-eclampsia and uterine rupture were higher in this group. A systematic review in the *Journal of Pregnancy and Childbirth* in 2014 found that although women who are Canadian born and immigrant women had similar expectations for their childbirth, immigrant women were more likely to have these expectations unmet. The greatest reason cited for this gap were difficulty in communication and lack of familiarity with the health care system (Small 2014). Sara's experiences with childbirth would have felt cold and alienating, without the support of extended family and without the ability to communicate both to fulfill her needs and to learn and master the vast body of knowledge needed to feel mastery and empowerment as a parent.

It is evident that we need to seek novel approaches to lessen disparate outcomes. The use of cultural brokers in health care settings is imperative. The availability of cultural brokers in delivery rooms and shelters and as part of cancer screening initiatives is also imperative. Our community in London, Ontario has a program called the "Women of the World" where women receive training to facilitate groups in their own language. The agenda of the support groups might vary from the most base settlement issue to legal counsel around abuse or to learning to advocate for one's own health (Torres 2013).

Sara is not her real name but her story is very real and all too common. She is resilient and she deserves to be empowered. She deserves equitable care.

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