ENGENDERING MIGRANT HEALTH

CANADIAN PERSPECTIVES

EDITED BY

DENISE L. SPITZER

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Canadian Perspectives

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A number of studies have shown that on arrival newcomers to Canada are, on average, generally healthier than native-born Canadians. However, research also indicates that after ten years in the country they experience poorer health, including higher rates of chronic disease, than those born in Canada. Migrant women – particularly those from non-European countries – experience the most precipitous decline in health. What contributes to this deterioration, and how can it be mitigated?

Engendering Migrant Health brings together researchers from across Canada to address these and other issues at the intersections of gender, immigration, and health in the lives of new Canadians. Situating their work within the context of Canadian policy and society, the contributors illuminate migrants' testimonies of struggle, resistance, and solidarity as they negotiate a place for themselves in a new country. Topics range from the difficulties of francophone refugees and the changing roles of fathers, to the experiences of undocumented migrants and queer newcomers. Throughout the volume the contributors stress the importance of social solidarity to community and individual health.

DENISE L. SPITZER is the Canada Research Chair in Gender, Migration, and Health and an associate professor at the Institute of Women's Studies, University of Ottawa.

This book is dedicated
in memory of
Michèle Kérisit
colleague, feminist, and friend

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1 Introduction

DENISE L. SPITZER

Is migrating to Canada bad for your health? Perhaps the surprising answer for some is ...'Yes.' While popular wisdom may presume that immigrants from poorer nations come to enjoy a better health care system, more advanced control of infectious diseases, a high standard of sanitation, safer working environments, better quality housing and water in Canada, all of which should contribute to better health standards than in their countries of origin, newcomers who reside in this country for longer than a decade often report a decline in health status. Although this trend is repeated in a variety of immigrant-receiving countries, disaggregating the epidemiological data that gave rise to these observations creates a more complex picture of this phenomenon (Llácer et al. 2007; see also Hyman, this volume). The healthy immigrant effect – so-called, as persons who choose to make migratory journeys tend to be in better health than the native-born populace (Hyman 2007; Newbold 2005b; Ng et al. 2005) – appears to be short-lived, with some immigrants reporting a deterioration of health status the longer they reside in their new homeland (Hyman 2007a; Newbold 2005b; Ng et al. 2005). Notably, non-European immigrants are twice as likely to report declining health status as their counterparts from European countries (Ng et al. 2005).

Within a biomedical context, poor health status is often attributable to deleterious health behaviours such as smoking and excessive alcohol consumption; however, non-European migrants are less likely than the Canadian-born populace to take up these activities (Dunn and Dyck 2000; Ng et al. 2005). Moreover, while newcomers are slightly less active than native-born Canadians, European immigrants who are less vulnerable to experiencing a decline in health status are the group that

reports the lowest levels of physical activity (Ng et al. 2005). In addition to their global region of origin, other factors including education, socio-economic class, marital status, official language skills, time of migration, and access to social support contribute to disparate health trajectories. Higher education and income, the ability to communicate in English or French, a spousal relationship, and the presence of a support network appear to militate against this decline of health status (Dunn and Dyck 2000; Newbold 2005b; Ng et al. 2005; Pottie, Ng et al. 2008).

Importantly, gender figures prominently when examining the loss of the healthy immigrant effect. In Canada, women, particularly those from non-European source countries, are most likely to report the steepest decline in self-rated health status compared to other foreign and native-born women and men (Vissandjée et al. 2004; Ng et al. 2005). Further analysis is needed to unpack the healthy immigrant effect – and its apparent loss – that attends to and accounts for both the heterogeneity of gendered, classed, and racialized disparities, and dynamism of this trend.

This book brings together researchers working across Canada to illuminate the complex, gendered dimensions of immigrant, migrant, and refugee health – included here under the rubric of migrant health. Importantly, we situate our work within the context of Canadian policies and society, that is to say, the historical specificities that impact current political and social relations and policy making, and have helped produce the unique profile of Canadian society that newcomers encounter upon arrival. Immigration, social protection, and health care policies help contour the social landscape by forging boundaries of inclusion and exclusion that new Canadians are required to navigate. The voices of immigrants and refugees in Canada are woven throughout the subsequent chapters, offering testimonies of struggle, resistance, and solidarity as individuals and communities negotiate a place for themselves on Canadian territory. Moreover, this collection offers insights into an array of gender issues ranging from changing fatherhood roles and the challenges of gay, lesbian, and bisexual immigrants and refugees to women's trauma narratives and the importance of social solidarity to communal and individual health.

Before offering a brief overview of Canadian immigration and relevant health policies to contextualize the readings in this book, I attempt to critically unpack some of the predominant terms used in discussions of gender, health, and immigration. Thereafter, I summarize some of the dominant issues confronting immigrants, migrants, and refugees

in Canada and consider how social location impacts these experiences. Finally, an overview of the book is prefaced by a description of intersectionality and our efforts to continue to operationalize it in our research and analysis.

A Word about Language

Before embarking on our further exploration of migrant health, it is necessary to complicate the meanings of various keywords and concepts that are central to this work. These include the terms *gender, race, visible minority, immigrant,* and *health* (cf. Vissandjée et al. 2007).

Gender

In its perhaps most common and most basic usage, gender is 'regarded as the socially ascribed attributes and roles assigned to the biological categories of, at minimum, the dichotomous pairing of male and female' (Spitzer 2005:80), while sex refers to the biogenetic underpinnings of male and female characteristics in anatomy and physiology (Spitzer 2006). Descriptions such as these invariably freeze-frame dynamic concepts reducing the ability for language to capture not only their complexity, fluidity, and diversity, but also the considerations of hierarchy and power that further inform them (Llácer et al. 2007). Neither sex nor gender is a stable concept nor are they evidence of fixed, 'natural' difference; instead, both are social constructions that may vary across time, socio-economic, geographical, religious, and ethnic boundaries, continuously recreated through performance, and subject to negotiation. The meanings and expectations of gender are expressed through gender ideologies that interact with socio-economic class, ethnicity, sexuality, geography, dis/ability, religion, and age, among other social indicators, to shape social hierarchies and structure access to determinants of health. Moreover, they shore up social disparities through appeals to the fixed and 'natural' nature of sex and gender differences (Mahler and Pessar 2001; Spitzer 2006).

From a population health framework that is meant to inform health and social policies in Canada, health is defined not as the absence of disease, but as the outcome of mutually influential determinants, including socio-economic status, social support, education, employment, both social and economic environments, health behaviours and personal coping skills, health services, gender, and culture (NFH 1997). Impor-

tantly, individuals are situated in the dominant social hierarchy as the outcome of the constellation of social indicators of which they are inscribed, resulting in differential exposures to deleterious physical and social effects (Doyal 2002; Spitzer 2005). Neither uniform policies and programs nor a focus solely on health care services provide sufficient theoretical or practical coverage to address health writ large. Efforts to address social and economic inequities, environmental degradation, human rights, and poverty are potentially important interventions to improve the health and well-being of a population (WHO 2006a).

Race

Authors in this text refrain from employing the term *race*, or employing race labels (*Caucasian*, *Oriental*, etc.) without complicating their use of those terms. Race labels are grounded in the presumption that sets of morphological differences among human beings (i.e., hair type, skin pigmentation, stature, etc.) can be collated and categorized under the rubric of four major races. From the time the eighteenth-century Swedish botanist Linaeus (Carl von Linné) introduced the scientific classification of human races, racial differences were imbued with judgments about the moral character and intelligence of each group, with Caucasians described in the most laudable terms (Smedley 1993). Gender figured in the construction of racialized differences producing a disparate range of expectations of roles and behaviour that reinforced stereotypes and which were themselves reinforced by scientific authority (Smedley 1993; Schiebinger 1999). Indeed, disaggregating human beings into disparate and rigid racial categories, a process that was informed by and which helped to further inform colonialism and its aftermaths, has relied on reputed scientific authority to transform race into a scientific 'fact' (Smedley 1993; Graves 2001; Li 2001; Grosfugel 2004).

Although anthropologists such as Franz Boas argued against the scientific validity of race in the early twentieth century, in more recent years geneticists, biologists, and other scientists, including those involved with the Human Genome Project, have likewise concluded that race is a flawed concept and lacking in scientific validity (Graves 2001; Duster 2003; Vissandjée, Hyman et al. 2007). Employing race labels in data collection can only work to reify race and racialized differences. Moreover, the diversity extant within these categories is erased in favour of a more homogeneous image, with little consideration given as to how individuals and groups identify themselves in terms of their origins and affiliation (Plaza 2004; Spitzer 2008). Li (2001) defines the ra-

cialization process as one that involves the assignation of social worth and social meaning to each racial category. To foreground the social process that is fundamentally entwined with race discourse, the term *racialized categories* is used throughout this text.

The lack of scientific legitimacy exposes race as a social concept rather than a reflection of biological fact. As a social concept that has relied on scientific authority to discipline racialized populations and provide a rationale for social hierarchy and its various manifestations such as colonialism and slavery, race can also serve as an important identity label and a space for forging solidarity and community (Duster 2003; Spitzer 2008). Notably a reduction or the elimination of the use of the term *race* does not lead to the reduction or elimination of racism. Indeed, systemic racism, embedded in institutions and reflective of dominant values that inform procedures, processes, and expectations (often read as 'common sense') disregards the role of social identifiers (gender, class, etc.) in the creation of social inequalities (Essed 1991; Anderson and Reimer Kirkham 1998; Li 2001). Furthermore, racializing processes help underscore the worthiness and unworthiness of individuals and groups of individuals who can be linked to the nation state through citizenship (Ong 2003).

Visible Minority

A related term, *visible minority*, also requires unpacking. Carty and Brand (1993) situate the uptake of this descriptor in the hands of the Canadian government. Used to speak to the apparently commonly shared experiences of racism, the application of a visible-minority label inevitably denies the unique, historically shaped relations between groups of people that inform experiences of racism and marginalization (Carty and Brand 1993). That said, the critical deployment of visible-minority status can speak to the ways in which individuals are relegated to racialized categories, how they respond to this assignation, and the consequences thereof; however, the contingencies of the term, including the masking of wide diversity of experiences and opportunities, must be made evident (Spitzer 2004).

Refugee/Migrant/Immigrant

The terms *refugee*, *migrant*, and *immigrant* are generally distinguished by the degree of voluntariness with regards to the decision to emigrate and by the long-term intentions of those attached to these labels to

settle in a new country. Citizenship and Immigration Canada (2008a) categorizes newcomers as (1) economic immigrants which includes skilled and business immigrants, live-in caregivers, provincial/territorial nominees and their immediate family members, (2) family class immigrants – spouses/partners, dependent children, parents, and grandparents – and (3) refugees: government or privately-sponsored persons who, fearing persecution, sought asylum in Canada. Refugee claimants, persons who apply for asylum upon or after their arrival in Canada, constitute another subgroup of Canada's foreign-born population (CIC 2008a).

Refugees, who are regarded as the most involuntary of newcomers, are often homogenized into a singular, uneducated, and unskilled mass. For refugees, temporary resettlement in a receiving country may well transform into more permanent residency if the situation in one's home country remains intolerable and/or if their lives built on Canadian soil become more compelling. Migrants refer to those who move temporarily, primarily for work; while the term may refer to movement within the boundaries of a nation state, it is also used to describe those who cross international borders. Temporary foreign workers or labour migrants may well enter the country with the intention of remaining, and, depending upon the temporary worker program in which they entered the country, there could be such opportunities. At times, the term *migrant* is employed to include both voluntary migrants (immigrants) and involuntary migrants (refugees). Importantly, the formal definitions of these terms are often supplanted by more flexible usage of the terms *immigrant* and *migrant* that are often used interchangeably in popular discourse and may further include refugee claimants and undocumented workers. Due to their elasticity and potential disparities between juridical and popular definitions, attention must therefore be paid to these terms to see how these categories are defined and deployed. Indeed, in a collection of this nature, it is difficult to impose a fixed definition given the range of approaches in the use of primary and/or secondary data and differences in foci from lived experience to statistical analyses.

The category under which a migrant enters the country determines not only her or his ability to become a permanent resident, but also structures access to auxiliary health services, education, and settlement services that are meant to assist with their settlement and integration into Canadian society. The assignation of one of these labels, therefore, has important consequences for individuals, their families, and

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