Immigration, Women and Health in Canada

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Canadian statistics show that one in six people are foreign-born comprising 17.4% of the total population and, with the exception of refugees, when immigrants arrive in Canada they are healthier than the Canadian-born population.¹ Two factors are attributed to the healthy immigrant effect: 1) Canadian screening procedures disqualify people with serious medical conditions, and 2) healthy people are more likely to emigrate.² Immigrant health deteriorates with length of stay in Canada. Current approaches to health have not adequately addressed this problem.³

While conscious that immigrant and/or refugee men also face declines in health status, we explore immigrant and/or refugee women's health as they are an invisible, isolated population within Canadian health interventions. Focus is placed on cultural, socio-political and economic issues in order to reflect upon future avenues for research. No one foreseeable solution to this growing problem has been identified but the experiences, lives and voices of immigrant and/or refugee women are necessary to lead us towards appropriate avenues.

Women, migration and health

Relations and perceptions are influenced by gender, race, ethnicity, nationality, religion, level of education, class, physical

ability, sexual orientation and social location. Both men and women participate in the global phenomenon of migration; however they experience this differently; immigrant women face triple spheres of oppression as women, workers and foreigners in their new country.^{4,5}

Women's health is perceived as a continuum that extends throughout the lives of women, critically and intimately related to their life conditions. Included among the determinants of health outlined by Health Canada are gender and culture.⁶ Nonetheless, pre- and post-migratory experiences remain unexplored as factors of women's health. Gender must be taken into simultaneous consideration with race, culture and social location within the context of an intersectional approach.

Controversial issues and immigrant and/or refugee women's health

Cultural, socio-political and economic environments impede immigrant and/or refugee women in maintaining their physical and mental health, affecting them profoundly at both family and individual levels. Certain mainstream perceptions of health, wellness and illness do not accommodate nor respect the cultural and religious beliefs of immigrant and/or refugee women.⁷⁻¹⁰ Consequently, health interventions should be formulated and implemented in ways that respect these differences while maintaining a standard of quality care. Culturally sensitive approaches must be developed for health and social service professionals in specific situations. Training for health professionals must prepare and equip them with necessary knowledge for providing quality care to a multicultural population.

Language barriers also create distance between the health system and immigrant and/or refugee women. Illiterate women, or those who speak neither English nor French, are powerless to personally access information on, as well as services from, the health system. They remain dependent upon others for information related to their own bodies. Using family or community members as interpreters is not always a solution as taboo subjects (sexuality) may be misinterpreted; professional interpreters should be used to ensure the accuracy of information.

Isolation and loss of pre-existing social support systems also affect immigrant and/or refugee women's health. Early hospital discharges (either after childbirth or illness) might cause fatigue and/or further ill health in immigrant women. In addition, refugee families have often survived great pre-migratory losses, long family separations, ruptures and traumatic events due to which their physical and mental health have already become fragile.¹¹⁻¹⁴ Refugee women have often cited experiencing rape, abduction, sexual abuse, harassment and/or the obligation to grant sexual favours in return for food or necessary legal papers before or during their migration processes, which exacerbate post-traumatic stress disorders.^{3,11,13}

Some sponsored women live happy and healthy lives while others face controlling and abusive husbands who threaten to cease sponsorship, abandon or return them to their country, ignoring Canadian law and the status and rights of immigrant women. Bound through multiple fears to their husbands and extended family, anxious for the well-being of their children, immigrant women are forced to accept vio-

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lence, leaving them bruised psychologically and physically and with a feeling of moral emptiness.^{*14,15} Furthermore, immigrant and/or refugee women from visible minority groups suffer additional prejudice and discrimination.^{3-5,12,14}

The reality of the double day is reinforced for immigrant and/or refugee women living in already tenuous situations upon arrival into a new country. Many immigrant and refugee women are vulnerable to excessive workloads, low wages, control, devaluation and abuse within their homes and places of work. Those that find employment before their husband risk facing repercussions caused by the perception of women's work within traditional gender role ideology. Further, they lose control of their earnings, which are handed over to the male head of the household. Immigrant and/or refugee women in these situations are more at risk of conjugal violence from a husband who perceives himself unable to maintain his traditional status as the family breadwinner. Finally, immigrant and/or refugee women might also encounter unemployment due to a lack of professional accreditation or education, or language barriers. These factors increase stress and depression and lead to low self-esteem.⁷⁻⁹

Where are we? Where do we go from here?

The Centres of Excellence for Women's Health Program (CEWHP) and the four Metropolis Centres of Excellence that span the country, work towards strategic interventions and research regarding women's health and migration respectively. Metropolis and CEWHP researchers working together have filled some of the gaps in research on immigrant and/or refugee women. Much more remains to be done in the area of immigration health research, such as: 1) evidence for considering the immigration experience itself as a health determinant³ and 2) a need for more intersectional analysis in this area of health research.

CONCLUSION

The growing immigrant and refugee population of Canada has largely earned research and policy attention in terms of demographic studies and economic integration. Yet, the gradual loss of immigrant health and well-being is related to multi-dimensional risk factors that are unknown prior to immigration. This lack of preparation erects hurdles with regard to the maintenance of the physical and mental health of immigrants and/or refugees.

Immigrant and/or refugee women face additional barriers to maintaining their health and well-being compared with immigrant/refugee men and Canadian-born women. Despite this well-documented fact, immigrant and/or refugee women are expected to change portions of their identity in order to "fit" into current health and policy interventions. Policies and/or programs are designed for immigrants in general rather than for immigrant women as a specific group; immigrant and/or refugee women's culture, heritage and ethnicity are necessarily compromised to fit into policies and/or programs developed for Canadian women, often treated as a homogeneous group.

Women's health strategies have been developed without consideration of cultural diversity, thereby hiding the faces of the many immigrant and refugee women who enrich the fabric of Canadian society. Culturally appropriate strategies must be developed to take into account the varied experiences and difficulties immigrant and refugee women face. Inappropriate models and programs, designed for a non-immigrant or male clientele, constitute an act of negligence by the Canadian health system whose mandate is to provide adequate care and services to the entire population. In erasing immigrant and refugee women from agendas, policies and programs, we impose detrimental alterations to their identities and encourage a continued deterioration of their health status.

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* In refugee couples and families, the preceding descriptions are also true, except that a husband cannot threaten his wife with abandonment and deportation since the family is considered a refugee unit and receives protection under Convention provisions.