

BENGALI IMMIGRANT WOMEN: HEALTH AND WELLBEING

[M]igration constitutes an experience of significant transition, offering new opportunities as well as many potential hardships. The immigration process – from the decision to migrate, to the journey itself, and throughout the settlement process – is a complicated affair...the new opportunities that may be associated with migration to Canada occur in tandem with the challenges of migration. As such, it is imperative that both the opportunities and challenges of migration are factored into the equation of immigrant health outcomes. (Vissandjée, Thurston, Apale and Nahar 2007: 224)

1. BACKGROUND AND THEORETICAL FRAMEWORK

Bengalis are an ethnic group most often merged with other subgroups of South Asians in Canada. South Asians are the largest visible minority group in Canada, but the ethnic, linguistic, religious and national or regional diversities within this group are often blanketed in this broad category (Islam, Khanlou and Tamim 2014). Even Bengalis are not a unified group as they can come from Bangladesh, India or elsewhere in the world, and may have Muslim, Hindu or other religious backgrounds, but they speak the common language Bengali, also known as Bangla. Bangladeshis are often referred to as Bengalis in common discourse, and also in some research including health research in Canada, the UK, the USA and some other parts of the world. For the purposes of this paper, the term “Bengali” has been used synonymously with Bangladeshi. The term “immigrant” has been used as a social construct (Li 2003) rather than a legal one as it is used in common discourse in Canada to refer to visible minority people irrespective of their legal status, length of stay or place of birth.

A few health studies have focused on the health experiences of Bengali immigrant women exclusively, especially in Canada. In most health research, however, these women are usually buried under the broader category of South Asian women, ethno-cultural minorities, or visible minority immigrant and racialized women. A search in the Web of Science, a multidisciplinary database of journal articles and conference proceedings, produced only two results when the words “Bengali immigrant women” and “health” were used – only one of those studies was Canadian, while the other was conducted in New York City. A better result was found by searching the same database using the words “Bangladeshi immigrant women” and “health.” A total of 19 articles including one letter appeared, but a quick analysis showed that none of these were from Canada. Ten of these studies were from the US, four from the UK, and two each from Australia and Finland. Another search using the terms “Bangladeshi immigrants” and “Canada” yielded six results;

however only one of them was found under “Public Environmental Occupational Health” while the others were under the categories of Sociology, Social Sciences Interdisciplinary, Psychology, Developmental and Geography. A comprehensive review of such literature was beyond the scope of this paper, but this quick search showed a research gap and the relative lack of research on smaller groups like Bengalis or Bangladeshis within the community of South Asian immigrant women in Canada.

Migration, as a determinant of health, tends to intersect with other social determinants, such as poverty, education, food security, employment, housing, racism, social exclusion and neoliberal economic restructuring to shape immigrant women’s physical, mental and overall health (Anderson 2006; Islam et al. 2014; Kobayashi and Prus 2012). The challenges immigrant women face in the new host country considerably influence their physical and mental health and access to health care (Islam et al. 2014; Vissandjée et al. 2007). Yet the health effects of migration, especially how women’s diverse experiences before, after and during migration shape the relationship between migration and health, still has not been explicitly elucidated in immigration and health research (Vissandjée et al. 2007). Intersectional analysis of migration as a complex social determinant of health and health care access was particularly absent in research about South Asian women’s underutilization of cancer screening services (Habib 2008, 2012). Similarly, migration, as it determines the experience of motherhood, has been largely neglected by researchers, and immigrant women’s experiences of infant feeding in particular have received little attention (Liamputtong 2006). To fill these gaps, South Asian immigrant women’s access to health care services, particularly cancer screening and obstetric and maternal care, was examined in the broader context of their migration and settlement experiences in two different studies in Greater Vancouver. The first one was my PhD research about South Asian immigrant women’s access to and experiences with Pap-smears and mammograms, while the second one explored infant feeding practices of immigrant mothers from different parts of Asia, including South Asia. I worked as a Research Assistant on the second project from 2010 to 2011, and I collected the data for the first project between 2008 and 2009. Both qualitative studies aimed to understand women’s health practices and access within the broader contexts of their everyday life experiences as shaped by the intersections of gender, migration and resettlement, and socioeconomic policies and processes.

Although the original scope of these projects was South Asian or Asian immigrant women, a few Bengali women participated in both studies. For the purposes of this paper, I have extracted and presented partial data from the Bengali women’s narratives about their health experience and use of different health services. This data showed that the experience of migration brought new expectations, opportunities and roles for these women, and also posed new challenges. Women in both studies went through financial and job insecurity and stress caused by un/der/employment, isolation and loss of family ties, support and social status, especially during the first few years following immigration – phenomena commonly found in the literature on racialized immigrant women (Guruge and Khanlou 2004; Vissandjée et al. 2007). These material conditions intersected with gendered ideologies and roles to shape these women’s health and wellbeing as well as their experiences of childbearing and parenting. Moreover, the powerful social and moral discourses of “good mothering” influenced their self-care practices so that while expectant and new mothers worked hard to take care of themselves for the best care and health of

their babies, the double duties of paid work and childcare made self-care hard for working mothers. Additionally, while young immigrant mothers including the Bangladeshis in the infant feeding study were inundated with health information and resources about neonatal care and parenting, information about cancer screening services such as Pap-smears and mammograms was not that abundant, as found in the other study, implying that immigrant women need to be viewed not just as “builders of better babies” or “future citizens” but also as entitled to equitable, healthy and fulfilling lives in Canada.

Bengali immigrant women’s health in this paper has been understood and analyzed within the social determinants of health framework informed by critical feminist antiracist and intersectionality scholarship. This framework views the health differences among Canadians as the result of social forces such as poverty, education, food security, employment, housing, racism, social exclusion and neoliberal economic restructuring (Anderson 2006; Raphael 2004), and also recognizes “the dynamic interplay between different levels of determinants” (Vissandjée and Hyman 2011: 259) because these factors complicate and intersect with each other. The multiplicity and complexity of the determinants and the multi-dimensional nature of health inequality in vulnerable populations demand that we pay attention to the processes through which the complex intersections of gender, race, class and other social relations operate in everyday interactions to determine women’s health and impact their ability to manage health and wellbeing (Anderson 2006; Kobayashi and Prus 2012). An intersectionality framework conceptualizes race, class, gender and sexuality as social constructs, and understands “...gender as inseparable from other forms of social differences” (Varcoe, Hankivsky and Morrow 2007: 9).

Critical feminist antiracist scholars have also critiqued the dominant neoliberal ideologies and understandings related to health care because these view health as an individual issue and as isolated from the socioeconomic policies, systemic inequities and historical processes that shape the differential life opportunities and priorities as well as unequal access to resources and health care for different groups of people. These ideologies largely fail to recognize and redress broader health determinants and public policies pertaining to economic opportunities, poverty, housing, service provision, and political inclusion and exclusion of racialized men and women. They also presume individuals, irrespective of their race, gender, socioeconomic and historical positions, as capable of making healthy choices and taking responsibility for their own health. As a result, those who cannot meet their health needs are viewed as “discredited citizens” (Fiske and Browne 2006: 106). Critical feminist and intersectionality health scholars, driven by the goals of establishing equitable health through removing structural barriers, have opposed neoliberal individualism and emphasized social justice and social determinants approaches to addressing women’s health issues and inequities.

2. METHOD AND SAMPLE

Qualitative data for both studies was collected through semi-structured in-depth interviews. Purposive or convenience sampling methods were used in both studies through an emergent and inductive process. In the cancer screening study, 5 of the 31 South Asian women were Bangladeshi Bengali (Habib 2012). All the Bangladeshi women were over 40

years old (range: 42-55) at the time of data collection during 2008 and 2009. Two of them had professional degrees but were unemployed at that time, and they had also stayed in Canada for less than three years. The other women had lived in Canada for at least 10 years, and were juggling full-time jobs in the service industry and childcare and household responsibilities at home. Four out of these five women had at least one chronic health condition including high blood pressure, diabetes and mild arthritis, and were taking some medications for these conditions.

In the infant feeding study, there were 16 mothers from China, Iran, The Philippines and South Asia (Chapman and Habib 2017). Data gathered from two Bangladeshi participants has been used in this paper. The women were 24 and 35 years old with an eight-month-old and a one-year-old infant, respectively, at the time of data collection between December 2010 and early 2011; they had lived in Canada for two to four years. Both of them were staying home to take care of their infants; only one had a few months of maternity leave, followed by a part-time job during pregnancy. Out of these seven Bangladeshi women in two studies, all but one had young children, and only one was non-Muslim. All were well-educated with a Bachelor degree at minimum.

All the interviews were conducted and transcribed by the author in both Bengali and English depending on the women's preference; Bengali interviews were instantaneously translated and transcribed. Both studies received ethical approval from the Behavioural Research Ethics Board at the University of British Columbia. Pseudonyms have been used to protect the identity of the participants. Using an iterative and dynamic process, the transcribed texts were categorized according to codes and sub-codes and examined for emerging themes. While the main focus of these two studies were different, namely cancer screening and infant feeding practices, such practices were examined and analyzed against the backdrop of participants' general health and wellbeing as shaped by the process of migration and its intersections with other social, structural and discursive forces in their lives. Much of this general and background data has been brought to the center of analysis in this paper. The analytical themes presented here emerged from the perceived similarities as well as dissimilarities or contrasts in the women's experiences in both studies.

3. FINDINGS AND DISCUSSION

In both studies, women talked about their gender roles, migration experiences and challenges, and how those shaped their health, self-care, parenting, health care practices and experiences with the Canadian health care system. Overall, gendered experience of migration, settlement and parenting in Canada shaped their health and wellbeing as well as their access to different domains of health care.

Gender, Migration, Health and Mothering

Women's experience in the cancer screening study showed that the process of immigration can cause physical, mental and financial stress and can affect health. Financial stress caused by un/der/employment, isolation and loss of social status, family ties and support were some of the common challenges shared by Bangladeshi newcomers. These shaped not only their health and wellbeing, but also their experiences of childbearing and mothering; this

was especially noticed in the infant feeding study. Lack of meaningful employment can create barriers to settlement and successful integration for immigrants, and can impact their health. A newcomer immigrant professional woman from Bangladesh voiced the frustration and mental stress experienced by most immigrants from South Asia due to non-validation of their professional degrees and lack of employment in their desired field of expertise:

I'm frustrated for sure! I can't get a job despite all these foreign [Western] degrees in my pocket! All these degrees are in vain! These degrees will give you jobs in other countries but not here! This is very hard to accept.... It's a lot of stress! No matter how hard I think I wouldn't stress out I can't help it!

Lack of employment or any earnings created not only financial stress but also a feeling of helplessness for Camellia due to her economic dependence on her husband: "If I had a job at least I wouldn't have to ask for money from my husband. Like right now, I have to ask for even pocket money from him. So I definitely feel helpless in that sense!"

Migration to a new country often disrupts people's social and financial status and lifestyle, and creates stress. For example, Gulmohar, another newcomer, was concerned about the high cost of medicine in Canada. She used this strategy: "Even I have some medicine from home so I don't have to buy here...so health care cost is minimized." As a skilled immigrant, she was working on obtaining Canadian accreditation; she shared that she was meagerly sustaining life since immigration by maintaining "a rock bottom lifestyle" and compromising her previous quality of life until she could obtain her qualifications to practice as a health care professional in Canada. She also articulated how the settlement process became more intense due to loss of support and reassurance from family and friends:

Mentally, there's lot of stress, like, going through this settlement process, especially the professional upgrading.... Also like, I miss extended family, especially my mother. And also, like, the social life – friends and family over there. Yeah – that is also something I always miss! It would be a source of comfort and pleasure – I miss that!

Life stress and anxiety disorders were found to be important mental health issues for South Asian immigrant populations in Canada (Islam et al. 2014). Often, despite having knowledge about healthy lifestyle and health promoting behaviours, women from South Asia including Bangladesh may be unable to continue some of these practices as a result of migration, which may interrupt the regular health behaviour or lifestyle practiced back home, and demand special attention and effort to put everything back in order in a new country (Choudhry 1998). Bela, for example, thought that South Asian immigrant women may have increased vulnerability towards certain health conditions and diseases due to the transformation of their "lifestyle and work habits" as a result of migration to a modern Western country like Canada:

Women in our [home] country, when they work, like, sit to do something or cook, they often stretch or squat and that's sort of an exercise as you bend your body and knees. Women in our country inadvertently do some kind of physical exercise [just through their daily housework]. So, our women, even though sometimes they may have different problems but they usually don't have many other gynecological problems.

Bela thought that many "modern-day gynecological problems" may be the by-products of a Western lifestyle – increased dependence on modern appliances and amenities that demand less physical labour. She also elaborated on how the physical stress of her menial

job impacted her overall health, adding that she believed many South Asian women suffer from similar problems:

I noticed that after working for a long time standing on my feet for eight hours at a stretch I started having joint pains. And since then I started having swelling legs and feet and many more physical or medical problems related to this. I saw doctors and still taking medication but I know I'm not alone – a lot of South Asian immigrant women I know also have similar complaints because we're required to work standing on our feet for such long hours. For women like us, we're not used to this, so we have problems. And it was really bad for me and that's why I had to change my job.

Such material conditions of immigrant women's lives can not only impact their health, but also shape their experiences of mothering, which became apparent in the infant feeding study.

The Bangladeshi mothers, along with many other Asian immigrant mothers, experienced a lack of extended family support combined with strong gendered divisions of labour related to childcare; they also often experienced a lack of financial stability (Chapman and Habib 2017). Not having extended family support increased challenges related to infant feeding and childcare, and caused stress. These mothers acknowledged professional support and help received from the Canadian public health system, but still missed the care, comfort and immediate support of close family members and friends. Fariha said, "As a new mom, I was really scared [nervous], because I didn't have any relatives here, so I really – it was scaring me." The transitional status and tight family finances due to migration influenced living conditions and the accessibility of extended family support. For example, Ivy said,

We were living in a small one bedroom apartment so having a newborn baby and at the same time having my parents over, it would be quite overwhelming for us...they are old people...they might get sick after they come here, after a long journey...so we later decided that my parents would rather come later than when we were giving birth to baby.

In fact, post-migration financial hardship limits the ability of most newcomers to sponsor extended family members to come to Canada, despite their need for extra support (Chapman and Habib 2017; Habib 2012; Koehn, Spencer and Hwang 2010).

Migration, Self-Care and 'Good Mothering'

Mothers in both the cancer screening and infant feeding studies provided "family-centric" or "altruistic" rather than personal reasons for self-care (Choudhry 1998; Koehn, Habib, Bukhari and Mills 2013). Many Bangladeshi women tend to put the care of their children and other family members ahead of their own – a tendency also noticed in many other South Asian women, especially the elderly who are inclined to have low priority for self-care (Koehn, Habib and Bukhari 2016) – and the wellbeing of family is central to their understandings of self-care (Koehn et al. 2013). This gendered and cultural notion of self-care, combined with the material conditions produced by migration, especially the double duty of childcare/domestic work and paid work, made it difficult for many mothers in the cancer screening study to make time for self-care. For example, Manju, a mother of three children, was managing full-time paid work as well as household and childcare responsibilities without much support from her husband. She recalled when her children

were younger she did not have any time for self-care although she was not working outside the home at that time. Once she went to a physician who noticed her pink eyes, of which she was completely unaware; the physician asked her, “Don’t you even look at yourself in the mirror?” As Manju said, being alone to raise her three children born as a result of shortly spaced pregnancies, she indeed had no time to look in the mirror.

Thus the gendered roles of homemaking and care-giving, along with the challenges of immigration and settlement, did have particular impacts on women’s health and access to health care for the mothers in the cancer screening study. They became subjected to time stress, which affected their scope for self-care as well as their access to “non-urgent” and preventative health services such as Pap-smears and mammograms. Henna recollected an incident wherein she faced the challenge of balancing both unpaid and paid work of childminding and self-care:

I had something pierced deep into my foot and I’m diabetic. But I couldn’t go to the doctor to get [a] tetanus [shot]. I went a day after because there was no one at home at that time and I was babysitting two other kids along with my own at home. So, how could I go?... When I went on the next day, you know what happened? I went to a walk-in clinic and they made me wait there for three hours! My daughter took a half day off [to babysit the kids] and then she had to leave all three kids with me at the clinic because she had to go to her work!

Unlike the Punjabi community, where most women live in extended families, most Bangladeshi women do not have the presence and support of relatives or extended family members. This is also the case for other smaller South Asian communities. For example, one Pakistani participant in the cancer screening study said, “Punjabi people bring their families – parents who can handle the kids. But we don’t have anyone, right?” Bela, a Bangladeshi mother, narrated her struggle to make time for a doctor’s appointment:

I have to make or adjust doctor’s appointments according to my work schedule and often I can’t even make it to a specialist appointment due to work. Or, maybe I need to go for ultra-sound test or to a doctor but I have work at that time, or my son is at home and so I have to stay with him at home as there’s no one to take care of him at that time, then I have to cancel the appointment. In case of my family doctor’s appointment I still need to check all these stuff to see if I can make it. I have to make cancellations quite often or change the appointment.

Despite these challenges, some of the South Asian women in the study said they tried to take care of themselves by eating healthy, taking regular medications and going to doctors when needed, doing light exercise and yoga at home and spending time with friends. One Bangladeshi woman said, “I started taking simple short courses like childcare, crafts-making – because that was my hobby and I needed that hobby just to hold myself together – without that I’d have lost my sanity! That was my way out [from stress]!” However, some of the women thought they should stay healthy because sickness can make taking care of family and children even harder and more stressful. This “family-centric” and “altruistic” notion of self-care was even more prominent in the infant feeding study, where expectant and young mothers from Asia often went above and beyond to take care of themselves during pregnancy and postpartum to ensure they would give birth to healthy babies and breastfeed them for the longest possible time (Chapman and Habib 2017). They felt a moral obligation to nourish themselves for the wellbeing of their babies. For example, Fariha, a Bangladeshi mother, said she became extra cautious about her diet, and even

though she felt nauseous while taking vitamin pills, she tried hard to take them because she felt she “should” do this for her baby. Liamputtong (2006: 25) found that Southeast Asian immigrant women in Australia experienced mothering as “a moral transformation of self” and were pressed to perform a “moral career...influenced by an ethic of care and responsibility for others, particularly their children.” This is also reflected in the narrative of Ivy:

My mom, she was also giving me lots of excellent advice over the phone. I became pregnant, she had started reading lots of resources and it is probably because she has sort of – it is my observation...that she has a guilty conscience. Like when she was pregnant with me and my brother she thinks that she didn't take the best care of herself and she thinks there was a lack of knowledge and lack of awareness from her side, but also the people around her.... So she was really cautious that it wouldn't happen in my case.

In addition, all the mothers said they maintained breastfeeding or did not even give it a second thought despite the challenges of lack of sleep, physical exhaustion and time demands. The increasing pressure on women in modern societies to be responsible for the nourishment, health and wellbeing of their children is internalized by mothers in the sense of moral and social responsibility for their children (Wall 2001). Mothers regularly participate in the social and moral constructions of “good mothering” through efforts to ensure the best possible self-care by maintaining a healthy diet and lifestyle during pregnancy and breastfeeding. Immigrant mothers’ efforts to negotiate with the discourses and expectations of “good mothering” may be further constrained by the challenges and hardships of migration. For example, post-migration financial hardship was raised by a number of immigrant mothers while talking about the expense of healthy foods and vitamin supplements. However, all the women regardless of financial status said that they did not compromise on these items, especially for their children. One Bangladeshi mother explained: “Well, we’re living on credit cards! Our financial situation is quite tight now but we’re not making any compromise with our food and health and the health of our baby!” Thus, women, irrespective of their migration status or ethnic backgrounds, can be subjected to the ideologies of “good motherhood,” but the experiences and difficulties of immigrant mothers can be magnified by the intersection of these ideologies with the economic, social and cultural conditions of their lives as immigrant women (Liamputtong 2006: 49).

Access to Health Information and Health Care Services

While young immigrant mothers in the infant feeding study were inundated with health information and resources related to obstetric and neonatal care and parenting, information about cancer screening services such as Pap-smears and mammograms was not that abundant for the participants in the other study. Although some of the new mothers faced some barriers to accessing these information and services, especially if they did not speak English or experienced time stress due to having older children as well as the newborn, all the mothers unanimously acknowledged the resources and support for pregnant and new mothers and infants under Canada’s public health system (Chapman and Habib 2017). Both Bangladeshi mothers in this study received health information and

support from the Community Birth Program in Greater Vancouver. Fariha described how she benefitted from the program she was referred to by her family physician:

The support is very, very good in Canada, and Vancouver especially, because I was in the...Community Birth Program, and they really helped me a lot! And even when I was giving birth they sent me a doula, so it was really good, and I was taking nutrition support from the program. So, it was good!

Ivy, another mother, shared a similar experience: “The Birth Program I was a member of, the midwives, the doctors, the nurses – everybody was so helpful in giving, in helping me through this very tough journey.” She particularly recognized the support of a community health nurse:

Our baby was crying constantly after she came home and we were wondering what's wrong...I was really thankful to that lady who visited my home, this nurse, because she kind of gave us a crash course just in an hour...she told us the baby needs to have some formula for a while and she taught my husband how to do that while I needed to take some rest. So altogether, I mean, she did a very excellent job. And that was the starting point for us.

On the other hand, health promotion programs and services for South Asian older adults and seniors are few and far between. The Bangladeshi women in the cancer screening study in particular did not seem to be well connected with community health services. For example, a South Asian Pap Test Clinic has been set up in South Vancouver to provide culturally acceptable services and to increase the participation of immigrant women in screening practices (Grewal, Bottorff and Balneaves 2004); but none of the Bangladeshi women were aware of this. Vissandjée et al. (2007) pointed out that lack of information and familiarity regarding existing services and the challenges of adapting to novel health care practices represent significant barriers to many recent immigrants' access to health care in Canada. The experiences of many newly arrived immigrant women in the cancer screening study also confirmed this, as participants did not have sufficient information, resources and support to help them navigate the Canadian health care system. Gulmohar, a relatively recent immigrant from Bangladesh, was unfamiliar with some aspects of the Canadian health care system, even with the process of getting a family physician. She did not know that a Pap-smear can be done by a family physician, despite being a very health-conscious person with a health care professional background.

In general, new immigrants and older adults with a lack of education/literacy and English language skills coming from rural Punjab in the cancer screening study were likely not to use screening services unless they had some symptoms, a family history of cancer or knowledge of prevention, or they received a recommendation, a referral and/or support from a family physician or community support worker (Habib 2012). In the case of the five Bangladeshi women, a complex set of personal, social and structural issues coexisted and intersected to impact their use or lack of use of cancer screening services – these included: not/having a family history, symptoms or knowledge; not/having information or a recommendation from a physician or community resource provider; not/having familiarity with the Canadian health care system; not/having fear/discomfort/embarrassment about exposing personal body parts; not/having beliefs about God's will and inevitability of illnesses; not/having childminding or extended family support; gender roles and responsibilities along with financial in/stability shaping their self-care and other priorities. Often, lack of transportation and dependence on family members for rides created

additional barriers to accessing cancer screening and other health care and community services for Bangladeshi and other South Asian women. Another study found that many Bangladeshi and Chinese immigrant women encountered difficulties related to obtaining transportation, childcare or time away from work, and language barriers, which led to dependency on family members for accompaniment and interpretation support; all of these impacted their cancer screening behaviour (Hulme et al. 2016).

Overall, there was not sufficient information, resources and support available for the under/never-screened women in the cancer screening study (Habib 2012). Even health literacy programs to educate women about cancer screening through pamphlets published in English or Punjabi tend to have limited success because many South Asian immigrant women, especially the elderly, have limited or no literacy in either English or Punjabi. As an observant and concerned participant, Camellia also pointed out the limitations of such an approach in educating South Asian women of diverse language and educational backgrounds:

I doubt that the leaflets or other stuff provided by the system actually can reach South Asian, especially Bengali women. Even if they do make it to the hands of these women, how many women can actually read and understand those! I don't know! And can they really fathom the significance or seriousness of the issue [of cancer screening]? I don't think so. I think either they don't understand or nobody really helps them to understand. Especially within the health care system, in hospitals, the doctors or the nurses – nobody talks to the women to make them realize that this is serious and you got to do it regularly. I don't think anybody takes that time to talk about these to the women.

Language and cultural barriers make health care services inaccessible for many South Asian immigrant women in Canada. South Asian immigrant older adults and seniors, especially those coming from rural areas of Punjab and conservative religious backgrounds, face multiple intersecting access barriers to health and social services and community programs, including isolation due to language issues, transportation difficulties, lack of knowledge of local resources, and childminding responsibilities (Koehn et al. 2016). Very few resources and community-based health promotion programs are available to address such access barriers and fulfill the unique needs of South Asian subpopulations such as Bengalis. Bangladeshi women in a recent study in Toronto highlighted how the Canadian system is different from the one in their country of origin, and how they used screening for the first time in their host country having had the information in their own language, and support from peers through a community-based project called Cancer Awareness: Ready for Education and Screening (Hulme et al. 2016).

As it has already been mentioned, immigrant mothers in the infant feeding study – in contrast to the women in the cancer screening study – were showered with health information and advice from the Canadian public health care system. Although mothers were generally appreciative of all the resources and support, from a critical feminist perspective, it seems that the Canadian health care system and other public discourses recreate the dominant view of women as mothers, and endorse the gendered ideologies and practices of mothering and parenting (Chapman and Habib 2017). Historically, South Asian women have been viewed as “creators of ethnic communities” and a “threat” to the whiteness of Canada, and were only allowed to come as wives and mothers during the late 19th and early 20th century as a measure of controlling sexual relations between South

Asian men and white women, and to maintain the racial purity of the nation by creating segregated ethnic communities (Dua 2000). These women continue to be viewed and prioritized as mothers, and as Wall (2001: 604) pointed out, mothers in contemporary society are being increasingly viewed and constructed as “builders of better babies.” Flooding immigrant mothers with health information and services also seems to serve the neoliberal agenda of health care reform and self-responsibilization for raising future productive citizens. Neoliberal ideals of motherhood expect women to “invest” in their children’s health and to generate human capital in the form of their children to meet the neoliberal notion of citizen self-sufficiency (McLaren and Dyck 2004). Immigrant women’s participation in the dominant discourses of mothering in Canada also allows them to demonstrate themselves as responsible parents and citizens, as “ideal” immigrants (McLaren and Dyck 2004) who are in charge of their own and their children’s health and can contribute to the project of producing an efficient future work force and healthy Canadian citizens (Chapman and Habib 2017). Within the same ideology, women, especially the older adults and seniors who are sponsored by or “dependent” on family members for support and care due to language, cultural and other structural barriers, are constructed as “deficient,” a “burden” or the “other” (Habib 2012).

4. CONCLUSION

Using the social determinants of health and intersectionality approach, narratives of Bangladeshi women from two different studies were combined and compared to explore how gendered experience of migration and settlement in Canada shape their experiences of health and wellbeing. The data showed that migration to a new country magnified the impact of gendered roles and ideologies of childcare and mothering. Discourses of “good mothering” also intersected with the material conditions of their lives and impacted their experiences of mothering and priorities for self-care. New immigrant women’s sense of wellbeing was shaped by a lack of accreditation of foreign education and work experience, un/der/employment, financial instability and lack of support from extended families. The differential experiences of women in the different domains of health care, namely cancer screening in comparison to obstetric and neonatal care, indicate that immigrant child-bearing women and new mothers tend to receive a lot more attention and priority from Canada’s public health system. This is a positive matter; however, older Bengali immigrant women from Bangladesh did not receive as much information and support for cancer screening. Health promotion services for South Asian older adults and seniors are generally not that abundant, but Bengali immigrant women in the cancer screening study were not connected to any. Similarly, much research has shown that many older South Asian immigrant women face many coexisting and intersecting barriers in accessing the limited health promoting programs and resources available for them.

Although the data and analyses presented here came from very small samples of Bengali immigrant women from Bangladesh, this paper constitutes an attempt to fill in a major research gap. Further research with bigger and more heterogeneous samples of this subpopulation of South Asians is needed. The timeframe of the two different studies in two different areas of health care was also slightly different, and this made the comparison of participants’ experiences difficult. Yet a few Bengali women’s voices represented here

(congruent with the general findings and voices of other immigrant women in the two main studies) show the need for tailored health promotion and other social services to alleviate health care access barriers and also for policy reforms to address social inequities leading to health inequities. Health information and service providers need to understand the internal diversity within South Asian communities and the variations of experience among these women, as well as the broader social, cultural, structural and systemic barriers that shape their health and wellbeing and access to health care and other services. Community-based approaches are needed to inform and educate Bengali and other South Asian older adults about cancer screening and other preventative care in Canada. More health promotion programs and community services with culturally specific outreach strategies are needed to serve Bengali newcomers, especially to help them deal with post-migration stress and hardship, and to support their self-care. Childminding services and transportation support need to be an integral part of such programs. In short, such programs and services need to address the diverse and unique needs and challenges of different groups of South Asian immigrants including Bengali women.

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