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Gender, Health, and Empowerment: Experiences of South Asian Immigrant Women in Greater Vancouver

Abstract: This paper situates South Asian immigrant women's health experiences in the contexts of their everyday lives as shaped by their immigration, relocation, and settlement processes in the Greater Vancouver area of Canada. Qualitative data was collected through in-depth semi-structured interviews with 30 self-identified South Asian immigrant women. Using the social determinants of health and intersectionality framework, this paper will show how intersecting social determinants including migration and gender affected South Asian immigrant women's priorities and understandings of self-care and also impacted their health and wellbeing. The material and everyday life conditions of these women intersected with systemic barriers to accessing healthcare and community resources and shaped their healthcare practices including the use of preventative cancer screening services. All of these intersecting issues, challenges, and barriers have significant implications for the marginalization and disempowerment of racialized immigrant women. Further implications of these intersecting social determinants of health in developing policies and practices to improve healthcare access and empowerment of South Asian immigrant women will be discussed.
Keywords: South Asian immigrant women, social determinants of health, healthcare access, migration and health, immigrant women in Canada

Introduction and Background

South Asians represent the largest visible minority group (close to two million) in Canada (Statistics Canada, 2017). Visible minority groups include people born in or outside of Canada who are neither Caucasian nor Indigenous. In the province of British Columbia, South Asians are the second largest ethnic minority group after the Chinese, and they are generally concentrated in the Metro Vancouver area (Welcome BC, 2020). Women from India, Pakistan, Bangladesh, Sri Lanka, and Nepal, and women of Indian origin coming from Fiji, East Africa, and the Caribbean are usually grouped together in Canada's common discourse as South Asian women. Yet significant ethnic, linguistic, religious, and national or regional diversities exist within this group, and these are often blanketed within this broad category (Islam, Khanlou, & Tamim, 2014). Rather than presenting South Asian immigrant women as a homogenous cultural group, this paper portrays their common experiences and struggles as racialized immigrants and how these influence their experiences of health and illness. It also identifies the differences in their experiences as determined by immigration, settlement and employment status, age, level of education and English language skill, and many other issues. 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.

Although Canada has high living and health standards and a publicly funded universal healthcare system, considerable social and health inequities persist for all women, particularly for ethnic minority, racialized, immigrant, and other disadvantaged women who face multiple forms of oppression (Varcoe, Hankivsky, & Morrow, 2007). Migration, an important social determinant of health, intersects with gender, class, level of education, poverty, and systemic racism and amplifies the experiences of inequities and discrimination for many immigrant women. The challenges immigrant women face in the new host country considerably influence their physical and mental health and access to healthcare (Islam, Khanlou, & Tamim, 2014; Vissandjée, Thurston, Apale, & Nahar, 2007). However, Vissandjee, Apale, and Wieringa (2009) note that the immigration factor has long been relatively ignored as an important health determinant within the social determinants of health literature, and also within intersectionality and health literature. The gendered experiences of migration as an important contributor to health and health iniquities among women has been integrated into health and migration research only in the past few decades, especially when it comes to how the relationship between migration and health may be strongly influenced by diverse experiences prior to, during, and after migration (Vissandjee, Apale, & Wieringa, 2009, p. 190).

In the area of breast and cervical cancer screening among immigrant women, a large number of studies show that compared to Caucasian and non-immigrant women, South Asian women have a low level of use of such screening services, namely mammograms and Pap smears (Habib, 2012). Few of these studies have examined migration as a predictor of low cervical cancer screening among South Asian and other ethnic minority women; even fewer have explored the ways race, class, age, and gender relations intersect with immigration and settlement status to shape South Asian women's access to preventive healthcare such as cancer screening services. In most of these studies, the ethnicity or nationality of different immigrant groups are conflated with their culture while ethnicity and culture are viewed as homogenous and static. Migration is understood only in terms of length of stay or the number of years women have lived in Canada, while the complex relationships among migration, health, and access to healthcare remain unexplored. Such theoretical and methodological approaches fail to take into account the broader contexts of ethnic minority immigrant women's lives including the challenges facing recent immigrants such as discrimination in the job market and the racialization of poverty. Intersectional analysis of migration as a complex social determinant of health and healthcare access was particularly absent in research about South Asian women's underutilization of cancer screening services (Habib, 2008). Thus, further research was needed that would be "sensitive to the experiences of migration above and beyond the recognition of cultural diversity" (Vissandjée et al., 2007, p. 222). To fill these gaps, South Asian immigrant women's access to healthcare services in general and cancer screening in particular were examined in the broader context of their migration and settlement experiences in Greater Vancouver. The qualitative study aimed to understand these immigrant 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 processes, and structural or systemic inequities.

My dissertation research focused on the wider socioeconomic contexts of racialized South Asian immigrant women's lives (Habib, 2012) by examining the intersecting impacts of their gendered experiences of migration, resettlement, and integration processes on their health and access to the Canadian healthcare system, especially breast and cervical cancer screening services. Drawing some examples from the South Asian immigrant women's breast and cervical cancer screening study, I will show in this paper how intersecting social determinants including migration and gender affect South Asian immigrant women's priorities and understandings of self-care, which in turn impact their physical and mental health. This paper will particularly focus on the gendered impact of migration on these women's health and wellbeing and generally discuss their access to healthcare including preventative cancer screening. Women's narratives in this paper about their migration, settlement, and health experiences will illustrate how they endured financial and job insecurity and stress caused by un/der/employment as well as isolation with loss of family ties, support, and social status, especially during the first few years following immigration. Their material and everyday life conditions intersected with gender ideologies and roles to shape their self-care and general healthcare practices in the broader contexts of systemic barriers to accessing healthcare and community resources. Lack of community support and accessible information about cancer screening services such as Pap smears and mammograms created additional barriers for the newly arrived immigrant women and for older adult and senior participants, especially those with little to no literacy. All of these intersecting issues, challenges, and barriers have significant implications for the marginalization and disempowerment of racialized immigrant women in Canada. Therefore, socioeconomic and healthcare policymakers and practitioners need to develop policies and practices in light of the social determinants of health in order to improve health outcomes and healthcare access, which will have empowering effects for South Asian and other racialized immigrant populations.

Theoretical Framework

Dominant biomedical conceptualizations of health usually focus on disease and ignore the social forces and contexts that shape women's health and lives. Although biomedical models have started to recognize social, psychological, behavioral, and gendered dimensions of health, it is feminist models of health research that place women at the centre of analysis and emphasize how gender as well as other social roles, rules, and relationships affect their health (Ruzek, Clarke, & Olesen, 1997). Critical feminist researchers conceptualize gender as a socially constructed power relation reflected in the social, political, material, discursive, and attitudinal differences in men and women's roles, entitlements, privileges, and positions in family, community, and society as a whole. Due to society's discriminatory beliefs, attitudes, and arrangements, women are denied autonomy and access to resources and positions of power in society (Wilson, 2000). Thus social, economic, and political inequities are produced, and these structural inequities impart profound negative influences on women's health. Yet gender should not be understood as an immutable social construction, because not all women are equally and completely powerless (French, 1985, p. 239). Rather, critical feminist and intersectionality perspectives recognize that gender often gives us power and options in some arenas and contexts while restricting our opportunities in others (Weber & Parra Medina, 2003).

Women's health in this paper has been understood and analyzed in light of 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). It also recognizes "the dynamic interplay between different levels of determinants" (Vissandjée & Hyman, 2011, p. 259), as these factors complicate and intersect with each other. Additionally, women's migration and re/settlement experience has been considered as an important social determinant of health and access to healthcare. The multiplicity and complexity of these 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 including immigration and settlement status operate in everyday interactions to determine women's health and impact their ability to manage health and wellbeing (Anderson, 2006; Kobayashi & Prus, 2012). An intersectionality framework conceptualizes race, class, gender, and other social relations as social constructs and considers gender as inseparable from other forms of power relations (Varcoe, Hankivsky, & Morrow, 2007; Varcoe et al., 2015).

For immigrant women of color, Anderson (2006) correctly insisted that gender relations cannot be separated from the processes of racialization, class relations, and other social relations that structure their lives, including ghettoization in the low-paid sectors of the labor market and exclusion from positions of power and privilege. Gender, race, immigration status, and class intersect to put immigrant and minority women at a great disadvantage and impact their ability to manage health and well-being. Therefore, a synthesis of race, gender, class, and sexuality through the lens of intersectionality may avoid inappropriate essentializing of women's experiences, and by so doing provide a better understanding of the diversity, subjectivity, and agency of women of color.

Method and Sample

A qualitative study was designed in order to situate South Asian women's health experiences in the contexts of their everyday lives as shaped by their immigration, relocation, and settlement processes. Qualitative data was collected through in-depth semi-structured interviews with 30 self-identified South Asian immigrant women. Purposive or convenience sampling methods were used through an emergent and inductive process. Ethical approval was received from the Behavioural Research Ethics Board at the University of British Columbia. Pseudonyms have been used to protect the identity of the participants. All the interviews were conducted by the researcher in English, Bengali, Hindi, Urdu, and/or Punjabi mixed with English with the help of interpretation from a family member or friend in some cases. In all cases, the participants and the researcher dialogued and negotiated to co-construct the data, and where an interpreter was involved, the interpreter also shaped the data construction.

Using an iterative and dynamic process, and with the help of qualitative data management software, all the transcribed interviews and researcher's notes were categorized according to codes and sub-codes and examined for emerging themes. The

analytical themes appeared from the perceived similarities and differences or contrasts in the women's experiences. While the focus of the original study (Habib 2012) was preventative cancer screening, such health 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 those general background data and analyses have been presented and focused here.

The South Asian women who participated in the study were born in India (15), Pakistan (7), Bangladesh (5), Sri Lanka (1), Fiji (1), and Kenya (1); they were all first-generation immigrants who had migrated to Canada directly from these countries or from a third country such as Tonga, the UK, or the USA and were living in the greater Vancouver area as either citizens or permanent residents. The majority of the women in the sample were from Punjab, India, which is reflective of the size of the Punjabi population in greater Vancouver. The majority were Sikh, while 13 were Muslim and one Buddhist. The majority were over 40 years old, with ages ranging from 31 to 76 years old. Nine had lived in Canada for five years or less, five had lived in Canada for over 20 years, and the rest fell somewhere in the middle. Most of them had post-secondary level education, while eight had little or no literacy or schooling. Overall, there was a good mix of highly educated to less educated women engaged in paid employment ranging from seasonal farm work or part-time service jobs to full-time self-employment and semi/professional jobs, while a few were retired, and most were housewives. Attempts were made to include a small but heterogeneous group of South Asian women with diverse ages, religions, countries of origin, mother languages and English-speaking skills, lengths of stay, and educational and employment backgrounds.

Findings and Discussion

The experience of migration and resettlement brought new challenges along with new expectations, opportunities, and roles for these women. Gendered roles of parenting and childcare, balancing paid/unpaid work, isolation and dependence, lack of self-care, and financial/physical/mental stress impacted their health and access to healthcare services. As the women shared information about their gender roles, migration experiences and challenges, healthcare practices, and experiences with the Canadian healthcare system, their experiences of health and wellness and their healthcare access shaped by these intersecting factors will be understood through the following themes:

Gendered experiences of migration and settlement

Women's experiences demonstrated that their roles and responsibilities as mothers, wives, caregivers, and homemakers were often complicated, amplified, and even transformed in the contexts of immigration and settlement in Canada. Most of the women were married with the exception of one single and one widowed woman, and eight were either divorced or separated. All of them were in heterosexual relationships, and all except the single woman and one married woman had children. For most of these women, immigration was mainly a family choice. Most women followed their husbands and came through family migration, even those with high levels of education and professional backgrounds. There were a few professional women who came as principal applicants, but

almost all of these skilled immigrants decided to migrate to Canada for the sake of their children or family. This is what three women shared about their reasons for migration:

> *– It's just that my husband wished to come here. He wanted to be here. He came here, so we came with him to stay together.*
> *– Well, my husband came here before me to make a good life. So I came here automatically.*
> *– Well, actually I didn't choose, because when I got married, I knew that my husband lived in Canada and that's how I'm here. It's not like I wanted to be in Canada and that's why I got married with someone in Canada.*

Early marriage along with lack of access to education was a gendered phenomenon observed among many participants, especially those from rural Punjab. Most elderly women experienced marriage and motherhood in their teens. For example, a 63-year-old woman who migrated from Fiji lost her mother at the age of four, got married when she was 14, and became mother of three at the age of 19. A couple of young Punjabi women were married at the ages of 16 and 17, and both went through divorce due to experiences of domestic violence. Most of the older adults and seniors from Punjab were sponsored by their adult children who came to Canada before them. They usually had a little or no formal education or English-speaking skills and lived in extended families with their sponsors. If sponsored by a daughter, they often lived alone or with a son who was sponsored along with them. Most of them were dependent on their sponsors in numerous ways: legally, for up to ten years; financially; for navigating and accessing Canadian healthcare and other systems; for transportation; and sometimes for care including medical care. Most seniors helped their older children with household chores and the care of younger children. By contrast, mothers from Pakistan and Bangladesh mentioned experiencing a lack of support with childcare from parents and extended families. As Zinnia shared,

> *Punjabi people bring their families—parents who can handle the kids. But we don't have anyone, right? If both of us get out of home, then who's going to take care of the kids? And then men care more about their kids than us, women! ... My husband says, you better stay home and take care of kids. We've come here for the sake of kids, for their betterment. We can't allow something bad to happen to them—they are our most precious assets, right? So for the sake of the kids, we better stay home and work from home.*

Immigration to a new country often transforms "traditional" gender roles and increases women's workloads. For example, a couple of housewives mentioned how they were forced to take on responsibilities in the public sphere, blurring the strict gender division between private housework and the public work of taking children to schools and doctors. "Everything you have to do by yourself here!" said Poppy. Zinnia explained:

> *We go to kids' school. Kids are completely our [women's] responsibilities, right? Husbands just work outside and earn money. Dropping off and picking up kids [to and from school], taking them to doctors when they are sick—everything is my responsibility.*

Zinnia also shared a story about how difficult it was for her to handle the new challenge of banking in public, something she had never had to do back home. As her friend Rose laughingly commented, "Some women don't even know where to sign on a check!" Such

gendered experiences of migration, settlement, caregiving, and parenting in Canada shaped participants' health and wellbeing.

Gender, migration, health, and wellbeing

Women's experiences revealed that the process of immigration can cause physical, mental, and financial stress and can affect health. Almost all of the professional women at the time of the interviews were un/der/employed; in particular, those who had been in Canada for less than five years endured financial hardship due to difficult employment situations. 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 the newcomers. Lack of meaningful employment can create barriers to settlement and successful integration for immigrants and can impact their health. A newcomer immigrant professional woman voiced the frustration and mental stress experienced by most immigrants from South Asia due to the non-validation of their professional degrees and lack of employment opportunities in their fields 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 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 even for pocket money from my husband. So I definitely feel helpless!" Champa felt it was disgraceful for a skilled woman to start working completely outside her professional field, but she realized that financial struggle and poverty force new immigrants to do such jobs, and this affects their health:

> *During this immigration process, after coming to Canada, my health has been affected too. On many occasion[s] I felt that yeah, it is not as good as before, and it is because of stress…. My health was fine … I was a regular exercise lady! Every day I used to exercise in the morning. I was regular to go to [the gym] for my sports. I like playing squash, and every evening I played for one hour.*

Migration to a new country often disrupts people's social and financial status and lifestyle and creates stress. Gulmohar, another newcomer, was concerned about the high cost of medicine in Canada. She had a strategy to cope with the situation: "Even I have some medicine from home, so I don't have to buy here … so healthcare cost is minimized." As a skilled immigrant, she was working on obtaining Canadian accreditation; meanwhile, she has been meagrely sustaining "a rock bottom lifestyle" since immigration until she can obtain her qualifications to practice as a healthcare professional in Canada.

Many recent immigrant women in the study experienced isolation and the emotional stress of leaving parents and extended families behind. Rose described the initial social isolation:

> *When I came here, I didn't know anybody here. I was all alone, so lonely! My husband left for work early in the morning. He came home late at night … few times I went to mosque to see if I knew any people. They were mostly Arabic people so I didn't go even*

there. I didn't know about the Fraser street, Main street. I didn't even know there was such an area. I was living in an area [where] just totally, like, white people live … the first three or four years [everything was] so unfamiliar … I didn't even see any woman in salwar-kamiz [a traditional South Asian outfit] ever… I used to cry a lot!

Stress and anxiety disorders were found to be important mental health issues for South Asian immigrant populations in Canada (Islam et al., 2014). Despite having knowledge about healthy lifestyles and health-promoting behaviors, women from South Asia may be unable to continue some of these practices as a result of migration, which may interrupt regular healthy behaviors or lifestyles practiced back home (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].

Bela thought that many health problems may be the by-products of a Western lifestyle, with its increased dependence on modern appliances and amenities that demand less physical labor. 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 this [menial] job.

Such material conditions of immigrant women's lives can not only impact their health but also shape their experiences of mothering and self-care.

Migration, parenting, and self-care

South Asian mothers in the study provided "family-centric" or "altruistic" rather than personal reasons for self-care (Choudhry, 1998; Koehn, Habib, Bukhari, & Mills, 2013). Most South Asian women tend to put the care of their children and other family members ahead of their own; especially the elderly are more inclined to place low priority on self-care (Koehn, Habib, & Bukhari, 2016) because the wellbeing of the family is central to their understanding 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 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 that 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?" Manju said that 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 caregiving along with the challenges of immigration and settlement had particular impacts on women's health and access to healthcare. Willson and Howard (2000) also observed that immigrant women and women living in poverty are particularly vulnerable to time stress and the health consequences of unpaid work because of their limited or lack of access to time-saving devices and resources. Women in the current study did become subject 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 where she faced the challenge of balancing both unpaid and paid childminding work with 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 lived in extended families, most Bangladeshi and Pakistani women did not have the presence and support of relatives or extended family members. A Bangladeshi mother with a special-needs child 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, 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 [and] 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]!*

Some of the women thought they should stay healthy because sickness can make taking care of family and children even harder and more stressful. Three women from Pakistan who were friends with each other expressed their thoughts and feelings about self-care:

Rose*: Yeah, I try to keep healthy because if I'm sick who's going to take care of my four kids!*

Zinnia*: Yes, I always think this way.*

Poppy: *I pray a lot to God that no mother may ever get sick! May everybody stay healthy!*

Another mother said,

> *My health has been affected because of my financial constraints and this kind of stuff…. I don't have enough money to take good food, but I think okay, for my baby I always try to buy good food, balanced food as they are in growing age. But for myself and my husband it is a problem.*

Such selfless mothering and "family-centric" or "altruistic" notions of self-care were even more prominent in another study about immigrant mothers' practices of parenting and infant-feeding, where expectant and young mothers from South/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, and felt a moral obligation to nourish themselves for the wellbeing of their babies (Habib, 2018; Chapman & Habib, forthcoming). Women, irrespective of their migration status or ethnic background, can be subject 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, p. 49).

Access to health information and healthcare

Nineteen of the 30 women had one or more chronic health conditions such as diabetes, hypertension, high cholesterol, arthritis, or back pain, and managing such conditions was prioritized over preventative cancer screening. Generally, the participants seemed to be more aware of and knowledgeable about these chronic health problems than about breast or cervical cancer. Many found it especially difficult to understand biomedical terminologies and processes like Pap smears and mammograms. Information about cancer screening services was not abundantly available to the new immigrants or to the senior participants. Vissandjée et al. (2007) pointed out that lack of information and familiarity regarding existing services and the challenges of adapting to novel healthcare practices represent significant barriers to many recent immigrants' access to healthcare in Canada. The experiences of many newly arrived immigrant women in the current study also confirmed this, as participants did not have sufficient information, resources, and support to help them navigate the Canadian healthcare system. Gulmohar, a relatively recent immigrant from Bangladesh, was unfamiliar with some aspects of the Canadian healthcare system, even with the process of obtaining 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 background as a healthcare professional.

In general, new immigrants with employment and settlement priorities and older adults with a lack of education/literacy and English language skills coming from rural Punjab were likely not to use screening services unless they had some symptoms, a family history of cancer, or knowledge of prevention, or if they received a recommendation, referral, and/or support from family physicians or community support workers (Habib,

2012). In fact, a complex set of personal, social, and structural issues coexisted and intersected to impact their use or lack of use of cancer screening services: 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 healthcare system; not/having fear, discomfort, or embarrassment about exposing personal body parts; not/having beliefs about God's will and the inevitability of illnesses; not/having childminding or extended family support; and not/having gender roles and responsibilities along with financial in/stability shape 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 healthcare and community services. Another recent study (Hulme et al., 2016) found that many Bangladeshi and Chinese immigrant women encountered difficulties related to obtaining transportation, childcare, or time away from work, as well as language barriers, which led to dependency on family members for accompaniment and interpretation support; all of these impacted their cancer screening behavior.

Community health promotion programs and services for older South Asian adults and seniors are few and far between. Most of the Punjabi seniors and the Bangladeshi women, irrespective of their length of stay in Canada, 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 increase the participation of immigrant women in screening practices (Grewal, Bottorff, & Balneaves, 2004); yet only a few women in the study, particularly those who were well-connected with community service organizations, were aware of and used such services. Overall, there was insufficient information, resources, and support available for the under/never-screened women in the cancer screening study (Habib, 2012). 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 after having received the information in their own language as well as support from peers through a community-based project called Cancer Awareness: Ready for Education and Screening (Hulme et al., 2016). However, without additional and appropriate support, health literacy programs designed to educate women about cancer screening through pamphlets published in English or Punjabi alone may have limited success, because many South Asian immigrant women, especially the elderly, do not have literacy in either English or Punjabi. As an observant and concerned participant, Camellia also pointed out the limitations of such an approach in educating women of diverse language, educational, and socioeconomic 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 healthcare system, in hospitals, the doctors or the nurses—nobody talks to the women to make them realize that this is serious and you've got to do it regularly. I don't think anybody takes that time to talk about these to the women.*

Obviously, language and cultural barriers make healthcare services inaccessible for many immigrant women and men in Canada. However, older South Asian immigrant adults and seniors, especially those coming from rural areas and conservative religious backgrounds, face multiple intersecting barriers to accessing 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 barriers and fulfill the unique needs of South Asian subpopulations such as Bengalis or Pakistani Muslim women.

Implications for Health Care Access and Empowerment of South Asian Immigrant Women

Findings showed that women's gendered and racialized experiences of migration and settlement created the broader social and structural contexts of their everyday lives within which they accessed healthcare services. Overall, women's settlement status and level of socioeconomic integration in Canada were impacted by traditional gender norms related to parenting and housework which became compounded by the social isolation, financial stress, and lack of extended family support experienced by most new immigrants. Women's length of stay in Canada since migration and their settlement status as well as their literacy, English language skills, and empowerment status were some of the key determinants of their participation in preventative cancer screening services in Canada (Habib, 2012). Elderly women with limited or no education and literacy or community networks were not using either or both cervical and breast cancer screening services.

Women's agency, empowerment status, and healthcare access

Findings showed that women's agency and empowerment status pertaining to their health-enhancing activities were shaped by their language ability, immigration and settlement status, time constraints due to gendered roles and family responsibilities, and community involvement. Anderson's (1996) study on chronic illness management among ethnic minority immigrant women showed similar trends where those with high levels of education and fluency in English with middle-class backgrounds were usually sufficiently empowered and able to manage their chronic conditions through changing jobs and gaining access to appropriate resources even when they did not receive much help from healthcare providers. On the other hand, women who were older and didn't speak English had fewer choices and less job mobility and access to community resources. Women in the latter group were "othered" or blamed as "discredited citizens" for their poor health within the neoliberal discourse of "individual responsibility" and "patient empowerment" (Fiske & Browne, 2006). Within the same discourse, immigrant women, especially older adults and seniors, who are sponsored 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).

Patient empowerment may have different meanings to different women. Yet the liberal rhetoric of empowerment, choice, and control over one's own body tends to overgeneralize or universalize men and women's experiences while ignoring the power relations and inequities between and among them. Such discourses of patient

empowerment and choice also render those unable to access resources and exercise their power and agency in so-called egalitarian and multicultural clinical and other settings into the "other." Critical feminist paradigms of healthcare suggest that empowerment is an outcome of changes in the fundamental structures and relations of power, including the relations between practitioners and patients, rather than individual actions and behaviors (Anderson, 1996, 2006). According to the same paradigm, as Anderson (1996) argued succinctly, handing over responsibility for care to the patient, who is viewed as a consumer, and involving all patients as decision-makers in matters pertaining to health, irrespective of their unequal socioeconomic, political, cultural, and historical positions, should not be equated with "empowerment." Such notions of empowerment embedded in the neoliberal ideology of individualism provide a rationale for shifting responsibilities to people who are least able to assume such liabilities and for victimizing and victim-blaming (Anderson, 1996; Fiske & Browne, 2006; Ponic, 2007). Within such discourses, despite recognition of the unequal socioeconomic structures that create health inequities, there is very little effort to enable disenfranchised people to become empowered by shifting those structures and arrangements.

Since language and effective communication play important roles in the negotiation of treatment choices and decisions, when women are not able to communicate well with their physicians, they may feel disempowered (Anderson, 1996, 2006; Tang, 1999). Elderly women without literacy and English language skills who have to depend on family members or other people not trained in medicine or healthcare for communication have little scope to show their agency, especially in relation to doctors whom they view as authority figures and experts. Anderson, Blue, and Lau (1991) pointed out that even when the patient and healthcare provider come from the same ethnic or linguistic background, "speaking a similar language does not guarantee communication" (p. 110). Interactions between healthcare providers and patients cannot be isolated from the power structures of the bureaucratic organizations within which they take place. Many patients feel intimidated by the bureaucratic nature of healthcare institutions and therefore hesitate to ask questions (Tang, 1999). Moreover, difference in educational status and social class hinder patient-practitioner interactions (Anderson, Blue, & Lau, 1991; Tang, 1999).

Social capital and healthcare access

Another important issue pertinent to South Asian immigrant women's empowerment is their community involvement, networks, and social capital. Social exclusion of immigrants with limited to zero literacy and/or English-speaking skills forces them to depend on their family and community members for access to services and support. As Vissandjee, Apale, and Wieringa (2009) noted, due to the poor health outcomes and health inequities resulting from social isolation and marginalization of immigrant women, health researchers, policymakers, and service providers have developed an increased interest in the social capital theory and focused on community-based approaches to health promotion. Such approaches can be beneficial to facilitate marginalized people's including South Asian women's access to important health information and resources and can have an empowering effect on them. Yet just as community can be a source of both support and oppression for racialized immigrant women, understanding social capital based on unity in racialized communities can impart both empowering and restraining

impacts on women's health and access to quality healthcare. Uncritical understandings of community as well as social capital tend to idealize and romanticize the notion of community and community bonding, hiding existing over-dependency, competition, jealousy, lack of unity, class discrimination, and exploitation (Bannerji, 2000). Depending on friends and community members may also lead to receiving inaccurate information or create stress and misunderstanding among friends who may not always be able to help.

From a critical gender perspective, social networks can be viewed as resources that support women's health, wellbeing, and empowerment, and alternatively as sources of control, isolation, and manipulation. Vissandjee, Apale, and Wieringa (2009) cautioned, "… a positive relationship between social capital, women's health, and women's empowerment initiatives cannot be guaranteed" (p. 195). They explained that in some contexts, high levels of social capital may enhance access to health information, break off isolation, and foster a more supportive and empowering environment leading to immigrant women's wellbeing and good health. However, in other contexts, women's participation and investment in maintaining traditional and cultural norms and values may not necessarily contribute to empowerment, opportunities, resources for themselves or for other women. These factors may actually enhance such women's "otherness" in Canada and hinder healthy behavior and access to health information and quality healthcare. Vissandjee, Apale, and Wieringa (2009) therefore suggested that "community health researchers and policy makers must contest and address policies that reinforce social inequity and marginalization as well as forms of social capital that are damaging to women's health, autonomy, and empowerment" (p. 195).

Healthcare access and the social justice perspective

The social determinants of health and intersectionality frameworks are informed by a social justice perspective to research and practice, which diverts our attention from individual responsibility for health and fairness in healthcare access to the broader structures, unjust systems, power relations, and social factors that create socioeconomic inequities and determine health inequities for individuals and communities (Varcoe et al., 2015). For example, underemployment and unemployment can have stressful and disempowering impacts on racialized immigrant women who are overwhelmed by the demands and stress of successful settlement and socioeconomic integration in a new country with limited support from the state. These women cannot be empowered simply by being showered with health information without any improvement in their sources of secured income. Improved access to basic literacy, English language training, employment with better payment and more benefits, childcare support, community resources, and appropriate health information will likely result in marginalized women's empowerment as well as long-term positive health outcomes and better access to healthcare, especially preventive care such as cancer screening. In general, more equitable social systems, arrangements, and policies will create empowerment for disenfranchised groups and result in more equitable health outcomes and healthcare access.

References

Anderson, J. (1996). "Empowering Patients: Issues and Strategies." *Social Science and Medicine*, Volume 43 (5): 697-705.

Anderson, J. (2006). "Reflections on the Social Determinants of Women's Health – Exploring Intersections: Does Racialization Matter?" *Canadian Journal of Nursing Research*, Volume 38 (1): 7-14.

Anderson, J., Blue, C., & Lau, A. (1991). "Women's Perspectives on Chronic Illness: Ethnicity, Ideology and Restructuring of Life." *Social Science & Medicine*, Volume 33 (2): 101-113.

Bannerji, H. (2000). *The Dark Side of the Nation: Essays on Multiculturalism, Nationalism and Gender.* Toronto: Canadian Scholars Press.

Chapman, G., & Habib, S. (Forthcoming). "Intersections of Discursive, Social, and Material Contexts of 'Good Mothering': Immigrant Mothers' Experiences with Infant Feeding and Nutrition in Metro Vancouver." In F. P. Guignard and T. M. Cassidy, editors. *Moving Meals and Migrant Mothers*. Toronto: University of Toronto Press.

Choudhry, U. K. (1998). "Health Promotion among Immigrant Women from India Living in Canada." *Image – the Journal of Nursing Scholarship*, Volume 30 (3): 269-274.

Fiske, J., & Browne, A. J. (2006). "Aboriginal Citizen, Discredited Medical Subject: Paradoxical Constructions of Aboriginal Women's Subjectivity in Canadian Health Care Policies." *Policy Sciences*, Volume 39 (1): 91-111.

French, M. (1985). *Beyond Power: On Women, Men, and Morals*. New York: Summit.

Grewal, S., Bottorff, J., & Balneaves, L. (2004). A Pap Test Screening Clinic in a South Asian Community of Vancouver, British Columbia: Challenges to Maintaining Utilization. *Public Health Nursing*, 21 (5): 412-418.

Guruge, S., & Khanlou, N. (2004). Intersectionalities of Influence: Researching the Health of Immigrant and Refugee Women. *Canadian Journal of Nursing Research*, Volume 36 (3): 32-47.

Habib, S. (2008). "Culture, Multiculturalism and Diversity: A Feminist Antiracist Examination of South Asian Immigrant Women's Utilization of Cancer Screening Services." *The International Journal of Diversity in Organizations, Communities and Nations*, Volume 8 (4): 187-196.

Habib, S. (2012). *South Asian Immigrant Women's Access to and Experiences with Breast and Cervical Cancer Screening Services in Canada.* (Doctoral dissertation). University of British Columbia, Vancouver, Canada. http://hdl.handle.net/2429/42855

Habib, S. (2018) "Bengali Immigrant Women: Health and Wellbeing," 69-84. In H. Zaman and S. Habib, editors. *Canada 150 Conference Proceedings: Migration of Bengalis.* Simon Fraser University, Vancouver. http://monographs.lib.sfu.ca/index.php/sfulibrary/catalog/book/73

Hulme, J., Moravac, C., Ahmad, F., Cleverly, S., Lofters, A., Ginsburg O., & Dunn, S. (2016). "'I Want to Save My Life': Conceptions of Cervical and Breast Cancer Screening among Urban Immigrant Women of South Asian and Chinese origin." *BMC Public Health*, Volume 16: 1077. doi:10.1186/s12889-016-3709-2

Islam, F., Khanlou, N., & Tamim, H. (2014). "South Asian Populations in Canada: Migration and Mental Health." *BMC Psychiatry*, Volume 14: 154. https://doi.org/10.1186/1471-244X-14-154

Kobayashi, K. M., & Prus, S. G. (2012). "Examining the Gender, Ethnicity, and Age Dimensions of the Healthy Immigrant Effect: Factors in the Development of Equitable Health Policy." *International Journal for Equity in Health*, Volume 11 (8): 1-6.

Koehn, S., Habib, S. & Bukhari, S. (2016). "S4AC Case Study: Enhancing Underserved Seniors' Access to Health Promotion Programs." *Canadian Journal on Aging / La Revue canadienne du vieillissement*, Volume 35 (1): 89-102.

Koehn, S., Habib, S., Bukhari, S., & Mills, S. (2013). *Achieving Self-Management Supports for Immigrant Seniors Team: South Asian Seniors Project*. Vancouver, BC: LiVWELL Research Group and the United Way of the Lower Mainland.

Koehn, S., Spencer, C., & Hwang, E. (2010). "Promises, Promises: Cultural and Legal Dimensions of Sponsorship for Immigrant Seniors," 79-102. In J. M. Michael and D. D Durst, editors. *Diversity and Aging among Immigrant Seniors in Canada: Changing Faces and Greying Temples*. Calgary: Detselig Enterprises Ltd.

Li, P. (2003). *Destination Canada: Immigration Debates and Issues*. Don Mills: Oxford University Press.

Liamputtong, P. (2006). "Motherhood and 'Moral Career': Discourses of Good Motherhood among Southeast Asian Immigrant Women in Australia." *Qualitative Sociology*, Volume 29 (1): 25-53.

Ponic, P. (2007). *Embracing Complexity in Community-Based Health Promotion: Inclusion, Power, and Women's Health.* (Unpublished doctoral dissertation). University of British Columbia, Vancouver, Canada.

Raphael, D. (2004). "Introduction to the Social Determinants of Health," 1-18. In D. Raphael, editor. *Social Determinants of Health: Canadian Perspectives*. Toronto: Canadian Scholars Press.

Ruzek, S., Clarke, A., & Olesen, V. (1997). "Social, Biomedical, and Feminist Models of Women's Health," 11-28. In S. Ruzek, V. Olesen, and A. Clarke, editors. *Women's Health: Complexities and Differences*. Columbus: Ohio State University Press.

Statistics Canada. (2017). *Immigration and Ethnocultural Diversity: Key Results from the 2016 Census.* https://www150.statcan.gc.ca/n1/en/daily-quotidien/171025/dq171025b-eng.pdf?st=RvgFZitx

Tang, S. (1999). "Interpreter Services in Healthcare: Policy Recommendations for Healthcare Agencies." *Journal of Nursing Administration,* Volume 29 (6): 23-29.

Varcoe, C., Habib, S., Sinding, C., Fitch, M., Gullatte, M. M., and Cummings, G. G. (2015). "Health Disparities in Cancer Care: Exploring Canadian, American and International Perspectives." *Canadian Oncology Nursing Journal*, Volume 25 (1): 73-92. doi:10.5737/236880762517381

Varcoe, C., Hankivsky, O., & Morrow, M. (2007). "Introduction: Beyond Gender Matters," 3-30. In M. Morrow, O. Hankivsky, and C. Varcoe, editors. *Women's Health in Canada: Critical Perspectives on Theory and Policy*. Toronto: University of Toronto Press.

Vissandjée, B., & Hyman, I. (2011). "Preventing and Managing Diabetes: At the Intersection of Gender, Ethnicity, and Migration," 257-272. In O. Hankivsky, editor. *Health Inequities in Canada: Intersectional Frameworks and Practices*. Vancouver: University of British Columbia Press.

Vissandjée, B., Thurston, W., Apale, A., & Nahar, K. (2007). "Women's Health at the Intersection of Gender and the Experience of International Migration," 221-243. In M. Morrow, O. Hankivsky, and C. Varcoe, editors. *Women's Health in Canada: Critical Perspectives on Theory and Policy*. Toronto: University of Toronto Press.

Welcome BC. (2020). *BC Community Profiles: Focus on Immigration and Diversity.* https://www.welcomebc.ca/Resources-For/Communities-Service-Providers/The-immigration-picture-in-B-C

Wilson, A. (2000). "Patriarchy: Feminist Theory," 1493-1497. In *The Routledge International Encyclopaedia of Women,* Volume 3. New York: Routledge.