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Immigration, Place and Health: South Asian Women's Accounts of Health, Illness and Everyday Life

Isabel Dyck

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Isabel Dyck

School of Rehabilitation Sciences
University of British Columbia
2211 Wesbrook Mall
Vancouver, B.C.
V6T 2B5
Canada
idyck@interchange.ubc.ca

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Introduction

This paper reports on a study of South Asian women's management of health and illness, particularly Sikh women who had immigrated to the Lower Mainland of British Columbia, Canada, from Punjab, India. The paper's focus is located within concerns over the particular vulnerabilities of immigrant women, seniors and children in having their health needs met, the apparent loss of the 'healthy immigrant effect' over time, and the relative underutilization of health care services by immigrants (Hyman 2001; Weerasinghe & Williams 2003). It is also informed by work on immigrant women's health, suggesting that changes accompanying processes of immigration and settlement are closely related to health and illness experiences in Canada (Elliott & Gillie 1998; Meadows *et al*. 2001). While concerns over immigrant women's health are located in a broadly defined 'social determinants of health' approach, which deflects attention away from individual behaviour patterns to social stresses and conditions, the problematic remains primarily informed by a health care service framework. Considerable attention has been paid to creating culturally sensitive health care and the development of culturally competent health care professionals, but it is not clear how successful 'multicultural interventions' are. In the Australian case, for example, it is found that disparities continue and reluctance in using the health care system remains (Manderson and Allotey 2003). Relatively little research has investigated how immigrants experience health and attempt to keep healthy, which would bring insight into the various issues noted above. The study reported in this paper reports on an exploration of the everyday experience and management of health and illness.

The paper investigates the management of health and illness as an integral dimension of the everyday lives of participants. It refers to data from individual and group interviews, focusing specifically on the ways women talked of 'keeping healthy' in the context of their everyday lives. The women's talk of place, health and healing provide an entry point into how we might frame the topic outside the assumptions of a biomedical health services framework and more fully contextualize it within broader issues of resettlement and 'belonging.'[1] In this analysis I am interested in how local environments are implicated in what women do and the knowledge they draw upon in managing their health, and that of their families. In the paper I first briefly outline approaches that have been used in attempts to explain immigrants' health behaviour and health care access issues, and then put forward the theoretical framing used in this analysis. This draws on work in geography that aims to connect materialist and humanistic orientations while emphasizing the centrality of place in understanding the

[1] This study is one of four parallel, comparative studies exploring women's use of home remedies, traditional healing systems and biomedicine in managing health and illness. The other studies focus on women in the broadly defined Chinese-Canadian, Afghani-Muslim and Iranian-Muslim communities in the Vancouver area. My colleagues in this work are: Dr. Parin Dossa and Professor Emeritus Anand Paranjpe, Simon Fraser University and Dr. Lyren Chiu, University of British Columbia.

dynamics of immigration and settlement. Turning to the data from the study, I start by discussing women's accounts of illness and health management and go on to discuss the women's engagement with place in analyzing more closely the conditions under which patterns of 'keeping healthy' and managing illness are constituted. The importance of social networks is emphasized, in the acquisition of knowledge and the process of decision making related to health concerns; options available include traditional medicine, folk methods and western biomedicine. In discussing these data I argue for a shift in the lens brought to issues of immigrants' health and health care, from one that tends to medicalize the outcomes of immigration stresses, to one that situates immigrants and their health within Canada's ongoing social and cultural transformation. In conclusion, I comment on the implications of the analysis for policy issues, particularly the necessity of incorporating a consideration of gender issues when thinking through programme development and service provision.

Immigrant Women, Health and Place

Two main models have been used in analysing the health status and health care access issues of minority immigrant groups: an approach that accords primacy to culture and one that focuses on political economy and the marginalization of minority immigrant groups. The culturalist approach has been particularly influential in informing critical theoretical work and practice in the health sciences. Personal and cultural factors, in combination with disease condition, are emphasized in explaining illness management strategies (for a recent example see Zhang and Verhoef 2002). Cultural differences are acknowledged, and expected to be registered in the practices of institutions and individual health care practitioners. Education in cultural competencies of those working with patients/clients is given high priority. The provision of interpreter services and written materials translated into the first language of non-English speaking (or non-French speaking in the case of Québec) major immigrant groups are other strategies, with these intended to overcome, at least to some extent, the well-observed language barriers that interfere with communication between health care professionals and their patients. By means of such changes in the delivery of health care, it is expected that immigrant minority groups who are 'culturally different' will receive better care and use the health care system more effectively.

Well-rehearsed critiques of culturalist approaches, however, point out the dangers of explanation based on an under-theorized concept of culture and, indeed, of the specific cultural constructs of ethnicity and 'race.' Not only can this lead to unhelpful homogenizing of ethnocultural groups, but also it masks the politics of knowledge whereby the naming and bounding of groups according to perceived 'cultural' characteristics tends to 'naturalize' difference and fix imagined communities. Ethnicity and race must be understood as situated social constructs, and should not

simply be associated with the difference of 'others' brought from other places, somehow intact. Culture should not be treated as a determinant of behaviour; rather culture is fluid, open to change, including repertories of health and illness, which are constantly in flux. Conceptions of health and illness and ways of managing these are reworked within the particularities of place, changed roles and experiences of the health care system (Dyck 1995; Elliott and Gillie 1998). Apart from theoretical inadequacies, culturalist approaches tend to neglect the fact that the 'host' community is similarly in flux, with identities and meanings of 'cultural difference' shifting over time and varying across space (see Strong-Boag *et al.* 1998, for a collection of essays on the shifting nature of social categories and identities over time in Canada's nation building, including that of 'race,' with chapters by Anderson and Reimer, and Dyck specifically relating these issues to Canadian health care provision). Furthermore, while structural and economic barriers may be acknowledged to influence health status, a culturalist approach cannot adequately incorporate these into a model of practice. Nor does the adoption of a culturalist model suggest ways of erasing such structural and economic barriers to health and health care.

Emerging in critique of culturalist approaches is a materialist/political economy approach. This focuses on labour market inequalities, including ethnic and gender segmentation, and the marginalization of racialized immigrants. Such an approach, through its focus on socioeconomic status and the material circumstances of everyday life, brings considerable explanatory power to our understanding of the health status of immigrants and the perceived under-utilization of health care services. Consistent with a social determinant of health approach, it successfully shifts conceptualizations of health status, at least in part, away from individual behaviour to group experiences – including the processes of immigration and settlement. For example, work on immigrant women, health and health care access has emphasized the structural, racialized, positioning of women in Canada in identifying barriers to health care access. Barriers include language and the 'double days' endured by women engaging in poorly paid labour while in the domestic context of households with highly traditional gender roles and life-worlds centred around family and friends from the same ethnocultural community. Examples from research shows that such 'superwomen,' who take the lion's share of reproductive labour as well as contributing to the finances of the household have little time or energy to 'keep healthy' or manage illness conditions, such as diabetes and arthritis, in prescribed ways or, indeed, to find time and opportunity to access formal health care services (Anderson, Blue and Lau 1991; Thorne 1993).

The implications of such a model are that attention needs to be turned to improving the lot of immigrant women and children who are at greater risk than others of poor health due to poverty (Hyman 2001). Yet the emphasis on the marginalization of many immigrant women (and groups) in Canada, and consequent constraints on their health and health seeking behaviours, tends to underplay agency. Research shows that women are not merely passive victims of social processes, but are skilled, knowledgeable agents who make pragmatic use of traditional healing systems and biomedicine (Dyck 1995; Stephenson 1995). These findings support the notion that pluralistic health care - that includes traditional and folk medicines – is best understood as 'smart consumerism' rather than a simple cultural conservatism (Kelner and Wellman 1997).

In this paper I do not wish to underplay the dislocation, isolation and losses that are reported by women immigrants to Canada, but I employ a framework that acknowledges women's resilience and agency and does not present women solely as passive 'victims' of a hostile social and medical environment. In this analysis I take account of both material circumstances and the power of the discursive construction of particular groups in effecting where they live and what they do, including their experience and management of health and illness. Specifically I draw on work in geography that is interested in the complex relationships among culture, health and place. Culture and identities are seen as fluid and intricately bound up with place (see Gesler and Kearns 2002, for an overview of work in health geography utilizing these central themes). Places are also understood as fields of knowledge and power in which individuals and groups are inserted differently, with gender, 'race' and class positionings, for example, shaping access to resources (Massey 1994).

In adopting this approach I am necessarily deflecting attention away from a medicalized view of health and healing, to one that explores health and health seeking behaviour as social and place-based phenomena that are integrally related to the settlement experiences of immigrants.

The Study: Participants and Interviewing

The data presented here came from individual, in-depth, semi-structured interviews with 10 Sikh women living in Greater Vancouver or its suburbs, and group interviews over four meetings with Sikh women (6 women in total) in Abbotsford, a small city in the Fraser Valley, which is the second most important destination for immigrants from India in BC, and has a long-standing and now rapidly growing Sikh community. All but two of the women had children of elementary school age; the exceptions were a woman who had children in her early teens, and a grandmother who took primary responsibility for the young children of her daughter-in-law. Their length of time since landing in

Canada ranged from 2 to 20 years, giving insight into both recent immigration experiences and established patterns of living in Canada, although most had been in Canada between 8-10 years. The women were either 'family class' immigrants, having come to Canada to join family members, or the spouses of skilled workers. In both the individual and group interviews women were invited to talk about various aspects of their lives: being a mother in Canada, household organization and daily routines, paid work and ways of managing health and illness. A focus of the interviews was on the everyday spaces and social practices of the women, seeking to examine how local environments were implicated in the ways women, as the primary health managers in families, managed health and illness.

The group interviews were designed to provide an opportunity to pursue issues in the women's lives in more depth and to promote a more interactive, story-telling mode of imparting everyday life experience. This was intended to provide not only more opportunity for nuanced accounts, but to move from 'public' to more 'private' rendering of life experiences (cf. Radley and Billig 1996). The group interviews were conducted in Punjabi, and the individual interviews in the women's language of choice. The research assistant interviewers were of Sikh background and had knowledge of Punjab, and in some cases of the specific areas that the women had come from. A thematic analysis was used, cross comparing across transcripts and group interviews. One research assistant also discussed the data closely with the author in order to interpret cultural nuances, expressions and helped situate the stories within contemporary methodological issues concerning 'voice' and power relationships in the interview process.

Study Findings

Health and illness experience. *"Oh God, how much work you have to do here"*

The women claim that their health has not appreciably changed since they have been in Canada, except for one who has migraines, which she attributes to stress about financial issues and marital problems, and another whose allergies have become worse. Their illness experiences in Canada, and those of their family members, are primarily associated with work and the environment, in the form of generalized stress, specific allergies to environmental and food substances, and work injuries. Some mentioned the high cholesterol levels of their parents or parents-in-law, which are dealt with through diet modification, and two husbands have chronic conditions they had prior to coming to Canada and that have become worse over time. What the women find most difficult in their lives is the amount of work they do, which they see as detrimental to what they are able to do to keep healthy.

In common with participants of other studies, these are women with busy schedules, irrespective of length of time in Canada, associated with their multiple identities as wives, mothers, paid workers and immigrants. All but one of the women living in Greater Vancouver are in paid employment, and those in Abbotsford are either working or attending immigrant settlement classes aimed to provide skill training in preparation for entry into the labour market. They rise early in the morning to make breakfast and lunches, go to work, make the evening meal, do housework, and look after their children. For the majority who live in extended or joint households, however, there is sometimes help with cooking or childcare from a mother-in-law or sister-in-law and, less typically, from a husband. The paid work of the women includes unskilled or semi-skilled work in restaurants, food processing plants and farm labour, this being typical of the type of work reported in research that points to the marginalization of immigrant women in the labour force.

Time is a scarce commodity and the women find little if any time to relax. Television is a usual form of relaxation if time can be taken from the routines of paid and domestic labour. All the women strongly expressed the importance of exercise for keeping healthy, but this is impossible for most to fit into their days due to lack of time. The one mother not in paid work stated she went for walks, either by herself or with her family, and the grandmother in the study finds time for some light walking exercise. The women contrasted life in India and Canada, commenting how exercise was part of everyday life in India whereas the work they do here (except for farm work), although hard, allows little opportunity for moving around or being outside.

Managing Health and Illness: Continuities and Change

In the absence of regular exercise and time to relax, what do the women see as important in keeping healthy? When asked about this the women, in common, spoke of two dimensions of everyday life they consider important in keeping healthy - prayer and healthy food. Desi medicines or home remedies are also used by all the women to a greater or lesser extent. The boundary between food and desi remedies is blurred, with the latter used in food as a preventative measure as well as in response to certain ailments.

> Prayer: *"[it] gives you something else to focus on other than thinking about other things."*

All the women talked of prayer as central to keeping healthy. As one women noted in the above quote, it is a means of distraction from everyday concerns. While its practice is institutionalized through temple (Gudwara) organization, prayer can be slotted more informally into daily routines. There are prayers of different lengths of time and for different times of the day.

Women, therefore, might confine their prayers mainly to the home setting while others attend the Gudwara one or more times a week. Prayer is typically considered an important part of everyday life and women attempt to incorporate some form of prayer into each day. It is to be noted also that prayer is a part of Sikh community life and identity, and serves to reaffirm one's self and community identity as well as being viewed as a way of dealing with the stresses and worries experienced by women in their day-to-day life.

> Food: *"We have outside food one or two times per week only, because we don't trust the meat here"*

Healthy food, not surprisingly, is considered key to a healthy life. In comparing and contrasting life in India and Canada, all of the women consider food ingredients to be fresher in India than in Canada. For most, especially those with younger children, most meals in the home are made from Indian recipes and often vegetarian, although a few cook Western food and meat at the wish of a husband or children. 'Outside food,' that is, Western restaurant food, as the above quote suggests, is not considered as high quality as home-cooked food, and a distinction is made between the food one can trust at home and that from restaurants. Food such as "MacDonald's," pizza and pasta however are readily accepted and liked by children, and in some households pizza and pasta are cooked regularly. Certainly older children are well used to what is considered Canadian food and its inclusion in a household's weekly menu, alongside Indian food, suggests that food is an important cultural and symbolic good that is negotiated as a marker of belonging and identity. One woman, for example, insisted her small child ate some MacDonald's food, as she thinks it is necessary for him to like this as a child growing up in Canada.

Information provided by Health Canada on healthy eating also influences perceptions of healthy food, whether Canadian or Indian. While women see their own way of cooking and fresh ingredients as part of keeping healthy, they also talked of Canadian dietary information that they try to incorporate in catering for their families. Wholewheat flour, instead of white, is used by some women in rotis, despite the less appealing taste. Women classify fatty, sugary, salty and spicy food as unhealthy and use much less butter and other common ingredients of Indian food in their cooking. Dietary advice, in general, comes primarily through the channels of the family doctor or school, with children as significant conveyors of 'new' food knowledge. The shift from parents as transmitters of health information to children was mentioned by several women. Television is a further common source of nutritional information. Body shape was a further topic discussed in the interviews, and women noted the changed meaning of a fat or plump body. Now, some women and children see 'fatness' as undesirable, whereas in India thinness had been seen as a sign of unhealthiness.

Necessarily, the social contexts of affluent and poor countries will make a difference to what is considered a healthy size, with plumpness signifying affluence in India as well as health. The point, here, however, is that body image, food, and health are intertwined in the women's talk about keeping healthy, with changes in the meaning of body size integral to identity negotiation and community belonging.

Desi/home medicines: *"Everyone must have a container of samf in their homes"*

All the women talked of home remedies and the value of certain herbs or spices to keeping healthy. They are used in looking after their own and their children's health, and sometimes that of parents and parents-in-law. Women do not make a clear distinction between food and 'remedy,' rather the two are talked about in the same framework. For instance, while *samf* is valued as good for indigestion and may be taken routinely after meals, a remedy made up of a number of ingredients including *samf* may also be used specifically for symptoms of sickness, such as a cold or flu. Like food, the freshness of herbs and spices can be guaranteed through their purchase at local markets, even if they are still seen as inferior in quality compared with those in India. The ingredients for making home remedies are kept in homes on a regular basis. Their use, therefore, is convenient and inexpensive. They are often used in a similar way as in India, although the mode of preparation might be modified a little or made easier as spices may be bought ready-ground in local shops or markets. The animated talk around examples of desi medicines brought to one of the group interviews indicated women's considerable knowledge and acceptance of their routine use in Canada. They are used for everyday minor ailments, such as colds, flu, allergies, and stomach problems, as well as for more chronic conditions, such as chronic pain. Desi remedies are often preferred to western medications because of their lack of side effects. It is accepted that their effect may be slower than biomedical approaches but that they are considered at least if not more effective in the long term. They are also less expensive to use than prescription drugs.

Like food, desi medicines signal an area of identity negotiation. Their value in Canada is still recognized by all the women, and all but one readily described how they used them in both a preventative way as well as in response to specific symptoms of illness or bodily discomfort. There is also some linking back to Indian life and relationships through such remedies; friends and relatives sometimes bring back ingredients for desi medicines after trips to India, while one woman's husband has remedies mailed from India for a long-standing condition that has not responded to western medical intervention. Desi medicines are a common first approach to illness that women can interpret as something they know and understood. If symptoms are outside their understanding, they will visit

a physician. Pregnancy and 'women's ailments' are also areas for western medicine, although a special food is prepared for women who have just given birth. Here again, the distinction between food and remedy is blurred.

Biomedical approaches: "*We rarely go to the doctor"*

Many of the women talked of their preference to try to 'fix' problems at home, before going to the doctor. If desi remedies are not effective, then a physician will be consulted. Typically, ailments of which women or their families have no experience or knowledge are ones deserving a consultation with a doctor. High cholesterol, for example, is treated by physicians, as is a long-standing heart condition of one woman's husband. None of the women have difficulties communicating with their physicians, as most have Indian doctors or ones that speak a little Punjabi. However, there were stories of misunderstandings over instructions of medicinal drug use and of misdiagnosis of conditions that the women said were well known in India. Some women commented that their doctors know they use desi medicines, but do not necessarily support their use.

Overall, women are highly strategic in how they use desi and biomedical approaches to managing illness; a combination of cultural knowledge of what 'works', convenience and cost are taken into account. One woman also spoke of the new knowledge of home remedies that she had learnt from other immigrant women in her workplace. Women are also receptive of 'new' knowledge about health and illness management that they learn through their children, newspapers and television. Keeping a healthy family is important to the women, whose lives – whether in full-time paid employment or not – centre on the viability of the domestic sphere and family relationships. As in the cases of food and desi medicines, the integration of western medicine into ways of keeping healthy and managing illnesses, is an important point of articulation in the complex relationships between 'mainstream' Canadian society, the local Sikh community, and a remembered India.

Social Networks: *"Us Indian ladies talk to each other and tell each other"*

A common Indian identity is as an important reference point for building social networks within which women negotiated and gained knowledge useful to them in living in Canada. During the course of the interviews and group discussions it was evident that social networks are central, both in terms of everyday social and material practices and in generating knowledge that informs women's interpretation of daily life. All live in some form of extended or joint household and/or have family or friends with whom they are in regular contact. The kinship term of 'auntie' (or uncle) is extended to friendship networks, extending practice from India. Friendship networks are place-based in two ways: first, friends are made through local workplaces (where women work together) or encounters in the

neighbourhood, such as in local parks or at their children's schools; and second, through references back to a shared understanding of life in India. Considerable chain migration has resulted in many people coming from the same or nearby villages in India, particularly in the case of Abbotsford, so that there are common experiential references from which to start a friendship. As one woman stated, a common opening to conversation with someone new from India is "Where is your village?"

Transnational interchange was not a focus of the study, but the data provided glimpses of ongoing contact with and references to 'back home'. Keeping up transnational links with relatives still in India through telephone or letters is common. In addition, visits to and from India were discussed in the group interviews and were referred to in the individual interviews. In addition to maintaining communication links with India, exchange may also take place, including bringing traditional medicines from India, as noted above. The 'remembering' of India, therefore, includes a material form that added to the experience of place in Canada.

These kin and place-based networks are important for sharing information, including the use of desi medicines, again regardless of length of time in Canada. In addition to potential sources of emotional and practical support, networks are critical to the 'processing' of new knowledge and experiences as women navigate and construct their life-worlds. Through information exchange and knowledge negotiation, they are also important in the negotiation of identity, acting as resources for women as they work out how to deal with change; for example, how to mother and be a wife in Canada including what it means to be an immigrant in Canada. The value of such informal 'talk' should not be underestimated; it is through such social interchange that cultural and social capital is built – informal social networks are rich sources of knowledge exchange. The reconstitution and reaffirmation of Sikh identities, as well as contestations of knowledge and 'ways of being' in Canada, are also the 'work' of social exchange in networks. This became clearer in the group interviews, to which I now turn.

Engagement with Place**:** *"I put on tea and start prayers"*

The group interviews echoed findings of the individual interviews but the dynamics and sustained discussion over four sessions provided richer, more nuanced data of 'living in place.' Here, by shifting the focus of analysis to the interchange between bodily experience, in the form of daily routines, and the specifics of a particular place we gain insight into conditions under which social networks are developed and health knowledge and practices negotiated. The different geographical scales of identity construction are also further illustrated in women's engagement with place.

Although Abbotsford is a small city, with a population of 122,000, it is the second largest destination of Indian immigrants to British Columbia and is one of the fastest growing areas in Canada. Much of the city's rapid growth comes from Indian immigrants, with 63.3% of all its immigrants between 1991-2001 coming from India. In addition, nearly three-quarters (72%) of the 'visible minority' population of the Census Metropolitan Area (CMA) is comprised of South Asians (2001 Census). 2001 census figures indicate that Punjabi is the leading non-official mother tongue in the CMA, and that there has been a 51.9% increase since 1996. A small, long-standing Indo-Canadian community, initially based on the lumber and agricultural sectors, has 'sedimented' over time, with a layering of immigrants coming from Punjab, with a high proportion of these sponsored parents, grandparents, spouses or fiancés.

The discussions of women's lives were indicative of 'thickly-lived place,' with new immigrants making connections through routine everyday activities. In addition to having ready-made family links, participants find it easy to make friends in a context of a flow of immigrants from the same area of Punjab. Homes, the neighbourhood park, shopping areas, schools and community programmes for immigrant women are all sites where women meet and talk, reconstituting their identities as mothers, grandmothers, wives, workers and immigrants. They commented on the ready availability of foodstuffs, herbs and spices and fabrics locally that enable them to live a life with cultural continuities, as well as change. Their gendered activity in gendered spaces is integral to how they see themselves as Sikh women in Canada, how they interpret 'place,' and, indeed, how they participate in the ongoing process of place-making. Such place-making also comprises landscape change; in addition to the 'marked bodies' and presence of South Asian 'others,' represented in dress, bodily comportment and language in this predominantly white community, institutions marking the presence of an imagined community of 'India' are visible on the landscape. These take the form of Gudwaras (Sikh temples), a Punjabi market, Punjabi language newspapers and schools. Daily routines, therefore, involve interaction with 'place,' materially as well as socially.

Reminiscent of processes in other places where there are dense, dynamic networks of social relations, these networks as Nast and Pile (1998:409) comment in the context of London, England, "frame the feelings, encounters and actions that comprise everyday life, in place, and through the body." But while there is an ongoing 'making of place,' much of this is through activity in gendered, place-based networks that produce conditions of support. It is to be noted that there may be a 'darker' side to the dense local networks through which lively engagement with place is put into operation. Normative ways of being in the world are constituted and reproduced, which may reaffirm highly gendered fields of power and knowledge (including patriarchal relations), which may be

disadvantageous to women. Furthermore, as Nast and Pile (ibid) also point out, such networks have a materiality, producing "specific racial and class patterns that mark, or scar, urban space…" This marking on the landscape of 'difference,' through bodily comportment, dress, and landscape features serves to etch a community as 'other' that may be translated into experiences of exclusion. The tension between support and conservatism that might be anticipated in conditions of dense network construction is deserving of further research and discussion in building up an adequate conceptualization of 'integration.' Examining women's experiences in relation to the 'host' population and other minorities, exploring how and in what situations a 'visible minority' community is constructed as 'different' and with what consequences is another area of research requiring further investigation.

Conclusions

Making place, keeping healthy

This paper shows that women keep healthy through means that are not only profoundly social, but are also closely related to place. The study reported here found social networks to be central in the constitution of women's lives, shaping what they do, where they go, and the knowledge that informs their interpretations of and responses to the conditions of their lives. In the case of these women, networks are built up in places where there has been rapid growth of the Punjabi Sikh population, with the 'village' often being a connecting point for new immigrants, and where supportive institutions have been developed and there is easy access to indigenous food and ingredients for home remedies. The women's descriptions of their daily routines seem to indicate a situation indicative of Casey's (ibid) notion of thickly-lived place, where there is a close intermeshing of places and identity, and a 'lively engagement" between people and place. But the potential for exclusions and marking as a racialized other takes us to the issue of 'belonging' and informal citizenship. The development of social networks in place-based South Asian communities in Vancouver and its region cannot be divorced from broader transnational migration processes. Conditions for the existence of dense local networks are produced through the complex interaction of global and local processes that are experienced, constituted and re-constituted in the ongoing 'making of place' at various scales, shaped by the political economy of labour markets, state immigration policy, and local service provision.

Findings from this study suggest that health and illness experiences are situated in a gendered settlement process; the women's accounts of keeping healthy and managing illness articulate their emplacement in local communities and a vision of themselves in Canada. Their accounts indicate their experience of racialized and gendered identities, and their ongoing negotiation of their place simultaneously in Canada as a nation state and in local communities; the women's multiple identities as mothers, sisters, daughters, wives, paid workers, and immigrants forge their relationships within these. The women can be viewed as active agents in community settlement and integration – again at these different scales – with the way in which they manage their family member's health, signaling the diverse sets of knowledge and methods that are brought to living an identity as an Indo-Canadian in Canada. The women's knowledge of western medicine and desi medicines from India represents cultural capital that translates into a pluralist approach to managing health and illness in community health care practices (Chacko 2003, makes a similar point about pluralistic medical knowledge as cultural capital in Kerala, South India). Food knowledge and nutritional information are also closely linked to managing health, re-negotiated in the Canadian context and representing cultural capital brought by women to the ways they navigate their engagement with Canadian society.

Implications

As has been recommended in studies adopting a political economy framework and a focus on the social determinants of health, this study supports the need for further attention to the ways that structural inequalities and 'naturalizing' discourses affect health status and use of health care services. The study confirms work that emphasizes the 'unhealthiness' of many immigrant women's work – the heavy demands of dual domestic and waged labour that creates stresses as well as difficulties in finding the time to keep healthy and access formal health care services. Indeed the immigration process in itself has been described as a determinant of health (Meadows et al, 2001). At the same time, women's use of cultural knowledge from their country of origin, reworked in local networks, together with knowledge acquired in Canada shows considerable flexibility in working out the conditions of everyday life in ways which support their family-centred activity. Their positioning in society as racialized immigrant women is an identity they experience and negotiate through the talk of their life in re-constituted 'Indian referenced' communities – not a re-creation of life in India, but one heavily informed by 'remembered' places, knowledge and ways of managing activities associated with their gendered identities. Nevertheless, the discursive practices of society that name and bound ethnocultural communities also affect how an identity is lived in the adopted country of settlement – it fixes an imagined community and contributes to its reproduction, so running into the danger of

unintentionally supporting an essentialist equation of culture with 'behaviour,' whether this relates to work or health practices.

There needs to be attention to redistributive justice of ideas as well as material resources if such 'othered' communities are to be fully admitted to the imagining of Canada. While the literature on social determinants of health directs our attention to material circumstances and inequities, more thought needs to be given to the discursive production of racialized immigrant groups - seen as 'less' than the unmarked 'host' society - through social and political practices mediated by a variety of discourses, whether the human capital discourse underpinning immigration policy (cf. McLaren and Dyck 2003) or those circulating in society through various media practices that inform lay perceptions of immigrants. Canadian society is in flux, as are national, regional and local identities, and integration needs to be thought about in ways that acknowledges the pluralities and fluidity of 'place.'

There needs to be more public education that demonstrates the contributions of immigrants to Canada – with this not confined to economic contributions but including the diverse ways immigrants contribute to healthy communities and populations, as well as the vibrancy of Canadian society. Further, the 'whiteness' of body image, food and health ideals needs to be acknowledged, so admitting the possibility of thinking through food as not simply interesting 'ethnic cuisine,' but as a cultural, symbolic and material good that has an important role in identity transformation.

In terms of programmes and services for immigrants, the findings of this study suggest the importance of continued funding of settlement services. Women-focused social networks are central to building cultural and social capital that is critical to how settlement is experienced in Canada, and how women contribute to the making of place. Service provision needs to recognize the importance of the contribution of women's reproductive work in the home and their active role as community 'makers.' Programmes need to facilitate social support mechanisms that can create culturally safe environments where immigrants can build cultural and social capital, particularly in the first few years of settlement. Specific funding of women's groups working in collaboration with local community workers, that target group-defined needs and use familiar 'story-telling' methods of discussion, would provide a means through which community resources could be strengthened and, thereby, the capacity to address health issues. Such group programme work has the potential to produce an effective pluralism to managing health that would be less costly, both monetarily and in terms of time, to the formal health care system and preserve a positive value for indigenous health practices, such as those of prayer, desi medicines and food choices, in a context where they sit dubiously in the shadow of the authority of western medicine.

In conclusion, findings from the data suggest that issues concerning immigrant women's health are also issues of 'belonging' and informal citizenship that need to be a more central part of work about immigration, resettlement and health than has been to date. The paper advocates a framework that brings health and illness and immigration and settlement experiences together, rather than separating out health and illness into the medical arena. This study focused on women's health and illness management, as women have been identified as a group that may not be having its health care needs met and are the primary caregivers of children, and so of the next generation of Canadians. Indeed, most research in the health and health care access of immigrants tends to focus on women. Gender is an important issue to address, as women and men are differentially positioned in Canadian society, with effects on their health, as indeed across world societies – with the power relation of gender being found to result in particular health outcomes for women (see for example, Dyck, Lewis and McLafferty 2001). Nevertheless, more research is needed on immigrant men that may bring insight into how immigration and settlement processes shape their health; for example, this study, while not focusing on men, did find that work injuries of husbands were spoken of by the women, as well as some suggestion of gendered ways of approaching health issues. Clearly, much more needs to be known about masculinity and health and illness management.

In sum, we need to think about the associations between gender, health and immigration that turn attention to social provisions and policies that can address the complex relations involved in place-making in multicultural societies. This, as noted above, needs to include recognition of fluidities – of group and individual identities, of places and of the very categories of analysis – in thinking about integration. As in health care, social policy and practices need to be supportive of 'culturally safe' environments for minority groups, avoiding the 'democratic racism' of multiculturalism that Henry and Tator (1994:8) describe in terms of a conflict between positively valued "egalitarian notions of justice, equality and fairness" and attitudes and practices in the populace that "include negative feelings about minority groups and the potential for differential treatment or discrimination against them." Similarly, following Ng (1993), categories used in research and policy making must be understood as dynamic, with, for example, gender, 'race' and class relations playing out in relation to productive and reproductive activities in the ongoing building of Canada as a social formation. Health and illness are not simply individual matters to be 'coped' with, but need to be set within complex interactions between health, place, gender and culture.

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