Transnational Health Promotion: Social well-being across borders and immigrant women's subjectivities.

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Recommended Citation

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Abstract

In this article, the authors use two qualitative studies to address transnationalism in the intersection of migration, gender and health promotion studies. The experiences of women who have recently (less than 3 years ago) immigrated to Canada are examined focusing on their transnational health promotion activities. Despite the invisibility of women's unpaid work in transnational and migration studies, we argue that the well-being of families, communities and nations is currently being produced in local, national, and international networks of health promotion and care giving and by the wealth generated by women's labour. Our contribution is to bring together gendered health promotion and transnationalism and to approach such topic empirically. In particular, we advance the notion of construction of subjectivities within transnational experiences. Subsequently, our analysis focuses on three elements that inform transnational health promotion from immigrant women's perspectives: expecting to live in a "better" place, giving and receiving care across borders, and women as transnational health promoters.

Key words: transnationalism, immigration, immigrant women, gender, health promotion, Canada.

Transnational Health Promotion: Social well-being across borders and immigrant women's subjectivities

For over four centuries, the establishment of the Canadian nation has been based on a continuous process of immigration and incorporation of people of diverse cultures, languages and values into the country. This pattern of populating the country with immigrants has been and remains today a salient feature in the economic, political and cultural life of the nation. Presently, the goal of Ministry of Citizenship and Immigration Canada is to have an annual population increase of 1% (Citizenship and Immigration Canada, Feb 8 2001, News release).

Countries such as Canada and Australia, "first world nations" with immigration policies, are seen internationally as heavens for those immigrating as refugees from war zones or immigrants leaving low income countries. Commonly, we assume (and frequently do not challenge) the notion that migration is a move towards a better life. Traditionally, immigration has been perceived as a process of moving to another country in search of prosperity, represented by a better socio-economic, political or spiritual life (commonly a South-North migration).

Challenging some ideas taken for granted: prosperity, health and gender among immigrants

Even though many benefit from peace and an established social welfare system when moving to Canada, due to a screening process, at arrival, the average immigrant to Canada is healthier and more educated than the average Canadian (Chen, Ng & Wilkins, 1996). Usually people can afford to immigrate because they were living in a reasonable economic condition (to study English or French, pay for immigration fees, health certificates, internet access to documents, etc). However, aspects such as who the immigrants are and the downside of immigration are not frequently addressed. Some recent studies show that immigration has numerous consequences that are complex and at times daunting. It is always disruptive and impacts physically as well as psychosocially on those who immigrate (Carballo, 2001). After 10 years in Canada, immigrants are in poorer health and have a higher prevalence of chronic health conditions (Chen et al., 1996, Dunn & Dyck, 2000). Also, a study shows that in the 90s immigrants in Canada did not progress economically (Canadian Council on Social Development, 2000).

In 2001, immigrants comprised 18.4% of the Canadian population (the immigrant population is described in terms of total immigrants, meaning all permanent residents born outside of Canada and recent arrivals). Contradicting traditional migration theory that assumes that immigrants are primarily male, women made up over half of the total immigrant population. Due to this traditional perception, often gender has not been considered as an analytical category in immigration studies. When women are taken into account, they are commonly perceived as either non-migrants who wait for their spouses to return or as "passive reactors who simply follow a male migrant" (Simon and Brettel, 1986, p3).

Additionally, studies on international health tend to render immigrants as static in one land after migration. This fixed or located understanding of immigrant experiences represents an important limitation in the way health promotion among immigrants is conceived. Immigration issues are examined in-situ and bounded by regional or national policies, which for sure are influential for immigrants' well-being, but this form of analysis looses the transnational health promotion experience of many immigrants (caring and being cared across borders, international social support systems), especially in their first years in a new country. Moreover, very little is known about immigrant women's strengths and their health promotion strategies in everyday life because most researchers have focused on pathologies and lack of access to health care, leaving the theme of production of health in everyday living unexplored.

This "situatedness" is also typical of many immigration studies. Usually the study of immigrant women's experiences has been divided by a myriad of ethno-cultural groups, and in some cases these studies have helped to perpetuate stereotypes regarding particular cultural groups (Gastaldo, Khanlou, Massaquoi and Curling, 2001). This approach has failed to identify the common experiences of immigration shared by women.

In this chapter, we will employ an interdisciplinary approach to address the intersection of immigration, gender and health promotion studies. Health promotion is explored here from the perspective of the social determinants of health. This means that health differences between different social groups can be explained by their social and economic conditions (Wilkinson and Marmot, 2003). Current research shows that "poor social and economic circumstances affect health throughout life" (Wilkinson and Marmot, 2003). For instance, the effects of migration and gender relations, such as employment opportunities or unemployment, equitable income distribution or poverty, the presence or lack of social support systems impact on the health of immigrant men and women differently and there are also differences between Canadian born and immigrants, as mentioned above.

In this context, we will utilize the concept of transnationalism to analyse the experiences of women who have recently (less than 3 years ago) immigrated to Canada. Our argument is that immigration turns many women into transnational health promoters. This role has been overlooked for not being "productive" or a formal employment activity or naturalised as "women's chores as usual", while in reality the well-being of families, communities and nations is also being produced in international networks of health promotion and care giving and by the wealth generated by women's labour.

In the following sections, we will situate the current debate around transnationalism and expand the concept in its relations to subjectivity and health promotion to capture its gendered character. In particular, we advance the notion of construction of subjectivities within transnational experiences. Later, we introduce two studies that provide empirical support to our argument, describing briefly their methodologies. Subsequently, our analysis will focus on three elements that inform transnational health promotion from immigrant women's perspectives: care giving and well-being across borders, living in a "better" place, and women as transnational health promoters.

Transnational subjects and the production of health

Like globalization, the concept of transnationalism has been used with ambiguity and over the last decade it has been defined in distinct ways (Kivisto, 2001). In this study our departing point is the notion of transnational social spaces (Faist, 2000a; Kivisto, 2001) as a social constructionist approach to transnationalism that allows us to explore the construction of transnational subjectivities by immigrant women who promote the health of individuals or

communities across country borders, using a post-structuralist notion of subjectivity to inform our analysis.

Despite the fact that global migration is certainly not a new phenomenon, the current globalization process has some particularities that make it singular. The fast pace of communication across the globe, easy transportation of people and goods, and economic exchanges between corporations that work beyond national borders compose an unprecedented process. These elements also support the experience of transnationalism; however, it is important to clarify the differences between these two concepts. While the globalization process tends to erase nation-states' powers and borders, transnationalism is a process anchored in the experience of living in between two or more countries and therefore it is framed on territoriality (Faist, 2000a), and we would add, consequently based on processes of cultural identity, difference, self and otherness, and the production of negotiated social spaces, among others (Gastaldo, Andews and Khanlou, 2004).

Transnationalism as a theoretical framework was offered by Glick Schiller, Basch and Blanc-Szanton (1992) as an approach for interpreting the experiences of immigrants. They argue that transnationalism is "compose[d] of those whose networks, activities and patterns of life encompass both their host and home society. Their lives cut across national boundaries and bring two societies into a single social field" (p1). Some believe it replaces the concepts of assimilation and cultural pluralism, while others would challenge this assumption (Kivisto, 2001). In essence, transnationalism is attempting to capture the "distinctive and characteristic features of the new immigrant communities that have developed in the advanced industrial nations at the core of the capitalist world system" (Kivisto, 2001, p.549).

From a post-structuralist perspective, we could claim that it is not possible to analyse the transnational phenomenon from a single position because macro or micro elements are produced simultaneously and are intertwined. Transnationalism includes economic, political, and socio-cultural aspects being created and negotiated by people living in between two places. For example, commodities and labour exchange between post-industrialized and "third world" nations are interconnected and create job opportunities or job losses as capital is re-directed from one nation to another; it includes political movements from ex-patriates living abroad which oppose a political regimen. However, in everyday life, there is also a flow of capital, for instance to support families in the country of origin. These small remittances, when placed together, account for over $60 billion US dollars annually (Vertovec, 2001). But collective and individual exchanges go beyond that. Constructs regarding gender roles and societal expectations regarding men and women are also "traded". Authors refer to multiple identities for a transnational social field, identities for translocality or transnational social spaces as sites for the (re)construction of one's identity (Vertovec, 2001; 1995; Glick Schiller et al 1992; Faist, 2000a).

Faist (2000) proposes that the concept of transnational social spaces includes transnational circuits and communities linked by processes of reciprocity, exchange and solidarity within

communities. He contends that not only negative forces (e.g. socio-economic discrimination) are conducive of the formation of these networks, but also positive political movements can promote their existence (e.g. multicultural policies). These characteristics have a lot in common with community development processes that women undertake in their work as caregivers and health promoters for families and communities. In the case of gender relations, there is a variety of positive and negative processes that could shape transnational social spaces. For instance, some immigrant women will feel so isolated in Canada that maintaining a close (daily) relationship with other women or family members in their home country can have a support/therapeutic effect; others continue to care for relatives, organise family events, or send money for children being raised by other women in the family using internet, phone calls, or travelling.

In this study, however, we expand the notion of transnational social spaces to encompass the power relations that produce multiple subjectivities and discourses in the process of maintaining communities and establishing exchanges (Gastaldo, Andrews and Khanlou, 2004; Gastaldo, 1997). For example, once women arrive to Canada, their subjectivities will be partially constructed as "immigrant", that happens to men too, but given the patriarchal relations they experienced in their previous place, they will have to learn how to function as immigrants at the same time that they negotiate their female subjectivity within particular gender relations in Canada. This process occurs in the intersection of other social constructs, such as class, race and ethnicity, which modulate sex roles and gender expectations for immigrant women. In this context, transnational social spaces may represent an opportunity for resistance to the imposed label of immigrant. Women can be on a daily basis in a social space, and not only a private one, where they are not seen as immigrants; their "old" personae can co-exist with the "new" immigrant one.

Transnational social spaces also produce subjectivities because they are helpful in keeping one's sense of social value (e.g. women can benefit from keeping their roles as emotional caregivers for family members who live abroad). Conversely, these same transnational circuits of care and health promotion can maintain gender inequities, such as roles of limited autonomy or many more daily working hours for women than for men. Living beyond "bipolar landscapes and localized identities" (Rouse, 1995:355 quoted in Vertovec, 2001) in a constant process of evolving multiple subjectivities can be a challenging experience, especially for immigrant women who are given and many times take upon themselves the responsibility of promoting the well-being of all family members, in occasions sacrificing their own well-being or disguising their sentiments of depression and loneliness so that the other members of the family do not suffer. As transnational health promoters they construct their subjectivities across different styles of gendered power relations and have in common only the continuum of gender inequity (a transnational cultural element) that can be made worse or better through immigration – or sometimes both happen at the same time.

Despite the fact that many recent immigrants maintain some degree of contact with their homelands, we adopt Faist's (2000) perspective that not all immigrants live in transnational

social spaces. As adaptation happens, some immigrants will live almost exclusively in their country of adoption; therefore, we believe that immigration is not synonymous with transnationalism.

This chapter's original contribution is to employ the concept of transnationalism into health promotion and gender experiences in the context of recent immigration, referring to cases where we have identified a process of living in a transnational social space, which includes the process of producing subjectivities. If transnationalism makes evident the circular flow of persons, goods, and information triggered by globalization, then included in this circuit should be the production of subjectivities, health and well-being. However, so far the transnational discourse has not been used to focus upon the ways in which migrants promote health using transnational skills.

Methodology

This chapter is based on two recent studies on immigrant women's health and well being when recently arrived to Canada (most under three years and a few under five). The first study entitled *Gendered Power: Immigrant women's health promotion(GP)* (Gastaldo, 1999) explored how women promote their own health in the context of immigration. Three focus groups were conducted with the help of interpreters and in total 15 women participated. In the project entitled *Revisiting Personal is Political: Immigrant women's health promotion (RPP)* (Gastaldo, Khanlou, Massaquoi and Curling, 2001) 30 recently arrived immigrant women participated in three focus groups (some had interpreters) and discussed how place, displacement and gender relations inform their experiences of health and well-being.

The participants of these studies were women from a variety of countries from Eastern Europe, Latin America, Asia, Arab countries, and sub-Saharan Africa; many would be considered women of colour in Canada. A few Europeans also participated. Many of those from so-called "third world countries" had shared experiences with those of "post-industrial nations" because they were from urban centres with "first world" facilities and services (access to internet, computer, health care insurance, tourism) and were used to consumption levels like middle class or upper middle-class people (or equivalent level of affluence). The majority had post-secondary education or a university degree and over half had professional careers in their home countries (what is common in the Canadian immigration context), but we also had some participants with few years of education or no employment experience. These attainments were irrelevant because all women faced similar hardships in Canada; most had not found a job at the time of the studies and their personal or family income was low compared to Canadian standards. The age range varied from early twenties to sixties, being younger people the biggest group. The participants were recruited in community health centres and English schools for immigrants. Women with children were the majority, but married women with no children, grandmothers and single women with no children were also part of the two studies.

In particular, the participants in the project *RPP* had a variety of reasons to immigrate. They

included, but were not limited to, educational goals for self and family, personal safety, and better quality of life. In reality, a number of women in this study immigrated to have a better quality of life. Many were willing to sacrifice their high standard of living for a better quality of life for themselves and their families in the future, Canada being considered a safer and peaceful country.

The data was transcribed and analysed originally to account for health promotion strategies among recent immigrant women. For this study, a secondary analysis was conducted, focusing on participants who referred to activities they undertake in a transnational social space ("living in-between places; being here and there"). It is important to notice though, that some women's narratives did not refer explicitly to transnational experiences, but rather they were mainly located in their Canadian life when commenting about daily issues and due to our theoretical perspective we located their perspectives as transnational themes, while other participants' experiences were not related at all to our subject of analysis. We have used the selected narratives to add new dimensions to the field of transnationalism in the context of immigration and health promotion.

Care giving and well-being across borders: a transnational migration strategy

Gendering transnational migration makes evident the extent of the changes that immigrant women experience. While it is acknowledged that transnationalism does not occur to all immigrants, we posit that it is only by looking into gendered social spaces that we can enlarge the possibility of identifying forms of transnational relations. The focus on immigrant women highlights a different experience of transnationalism from their male counterpart. As such, the adjustment of women to a new country cannot be fully understood without an appreciation of the continuing kinship links across national borders. This link not only provides support for women and allows them to construct their subjectivities, but it also imposes new challenges, duties and responsibilities.

The decision to leave children behind or the act of sending children back home to be cared for commonly by a maternal grandmother is a transnational migration strategy. A focus group participant in the study *RPP* talked about the difficult decision of sending her daughter back to China to live. She said:

This summer I make a very, very difficult decision; it is difficulty, I send my daughter back to China. It is very difficult, I thinks very bad situation… My mother, she is there, takes care of my baby... so my husband and I can work and study. I think three years later we will have a better future.

This course of action utilized by some immigrants is a way of coping with a new situation and includes a great degree of compromise. Employing this as a strategy allows both "husband and wife (to) acquire jobs and work long hours, hoping that they will be able to achieve their financial goals in a shorter period of time" (Simon and Brettell, p.13). This financial goal could either be to become financially stable to care for a family with children or to become financially stable to

return to their country of origin.

For women, leaving a child behind or sending a child back "home" is an attempt at combining old gender roles with their new roles as immigrant women in Canada. By sending children back home, the women expect that they can still maintain some aspect of their role as care giver (emotional and financial) for their children, albeit across borders. This idea or consciousness about themselves and about their "role" as women and mothers determine the women's subjective experiences. Caring for their children across national borders allows women the time to perform two other jobs that they often did not have to perform in their country of origin – paid work and/or housework, even though many had chosen to have a professional career. In some cases, women tried to access training and opportunities to develop marketable skills that they hope will increase their monetary return on their paid work. The expanding roles of immigrant women allow some to raise their child in two places while allowing them to achieve better economic life before the child rejoins the parents. This is of course rooted in one of the primary goals of most immigrants, to give their children a better life than they had.

Care giving and well being across borders is certainly not a new phenomenon. However, improved technology, permitting relatively faster and easier access to such things as the telephone and the internet allows for a kind of social support network that has not been available to new immigrants in the past. This has far reaching implications for the mental health of immigrants. For example, a participant in *RPP* spoke of her emotional anguish at being separated from her family in this exchange with the group moderator and another participant:

P1:...the moments that I like during the day? Those times when I talk with my mum in [home country].

M: Do you miss her?

P1: Very much. And I speak with her very often, like almost every day.

M: For how long have you been here?

P1: Eight months. It's the first time that I separate, and it's very hard for me (cries).

P2: For me also very hard. Has been for ten years that I been living outside (country), and I know that first year is really hard. And I also call many times a week my family. (…)

P1: I have a camera, and through Internet I can see her almost every day.

Certainly then, the use of telephone and internet allows for new dimensions of transnational caring by permitting immigrants to live emotional lives in two countries. For instance a participant in *RPP* explained that she is able to attend monthly family meeting via her phone and

her father's cell phone. As she described:

Normally we have a family meeting. Like today, I meet [name of relatives].

We have a family meeting once a month and I knew about this meeting. So what I do is I call my father, my father's cell phone, so that I can speak to him.

This transnational connection, made possible by improved technology, not only allows women to care and to attend family needs, but it also speaks to the fact that this ability may generate an expectation of continued care by friends or family members, despite the location, times and costs of such contacts.

However, other women temporarily trade their role in their country of origin for a social space that allows for the (re)construction of their subjectivity (Vertovec, 2001). For example, one participant spoke of her country's oppressive gender role for women that she escaped by immigrating to Canada:

I have brothers and sisters, but being the first-born girl, I have the responsibility almost equal to my mom. (…) I wanted to have my own freedom. Because like, if I stay there, I am not going to do this for my family, it's like I am being so rude, I'm being so unappreciative, it's like … Your family, your parents did so much for you and you cannot even see that. No matter what you do, but it's forever, you are bound to them… my father believes that I'm in school that was the only reason that I could go away… he also needs to know that I still love him and that I am his "mother" and that nothing has changed and that when I'm through with my school, I go back and take my responsibility [in her culture the oldest daughter carries the spirit of the mother of the father].

It would be too simplistic to say that migration here implies emancipation for this participant, but as an immigrant, the (re)construction of her social space allows for a reconciliation of her old role with her new (desired) role. For this participant, migration represents a definite improvement in the construction of a social space for gender relations. This new role allows for greater control over her life, while letting her to maintain her care giving role in the family by sending money and allowing her to have weekly family meetings with family via the telephone.

The examples here presented illustrate that there is a variety of processes that shape women's subjectivities in transnational social spaces. While a strong transnational link with relatives in the country of origin can act as a support system for women to face the difficulties of adjustment in the settlement process – thus maintaining some aspect of their "old" subjectivity while acquiring a new one – the new responsibilities in the country of adoption added to the old gendered activities can become an overwhelming experience.

Living in a "better" country and expecting to be healthy/happy

Migration is inextricably linked to the perception of changing conditions. Commonly, one perceives that his/her personal circumstances will change for the better during the process of immigration. Most participants in our studies left their countries of origin with vague concepts of the immigration process but had broad notions of achieving the "American Dream" or living a Western lifestyle once reaching their desired destination. Information about Canada was obtained primarily from external sources such as immigration officials, family members and the media.

The participants' personal agendas and physical and emotional responses in their new country were created through a "complex cultural and physiological process which manifests itself at both an individual and at a social level" (Carballo, 2001). These psychological responses impact on immigrants' health and well being. Immigration requires a break with tradition, community and family, cultural value systems and accepted ways of functioning and dealing with the world (Carballo, 2001). It then imposes demands on immigrants to quickly develop new psychological and social survival skills at a time when they are already anxious or feeling stressed about the migration process or at a time when the host society is unwilling or unprepared to offer support. In the case of women, this context is particularly demanding because many also feel responsible for the well being of the entire family and, despite not receiving much support, will try to provide as much support as possible to family members.

The participants clearly were able to articulate how the imagined new country (perhaps equitable, non-racist, progressive, among many other possible images) did not correspond to the reality of day to day living in this new environment. One woman in the *RPP* study described her experience as follows:

Everything is difficulty here; maybe nice country… I don't know, you know, just what we saw in the movie, not exactly the picture of Canada, that's all. In our minds we maybe thought that Canada is maybe easier than our country. Yes it's easier, but it's difficult for job and other things…

Others added that in Canada "the men have more job opportunities" and there is "low wages for women". And still a participant said "I think job is very difficult in Toronto" and another commented:

So there are barriers, there are barriers. Because of maybe people not really know about your background, just because of they don't know you; just initially they don't know, they just judge you by your race; judge you by you are female. Because I still feel female have to fight harder. (…) And as a, ah...immigrant also have to fight harder as well.

Beyond being a woman and an immigrant (and experiencing sexism and xenophobia), some participants had to deal with mixed sources of oppression, such as racism, ageism, and discrimination based on physical or mental health. Salih (2001, p. 655) suggests that "rather than

a uniform process, transnationalism is a complex and varied terrain experienced differently according to gender and class and their interplay with normative constrains". This segment of the population is particularly vulnerable because of these intersecting prejudices that can serve to disempower and thereby lead to feelings of helplessness and low self-efficacy (Henry, Taton Mattis & Rees, 1995; Turner, 1995).

Living in Canada can be disempowering for women also because they are forced into new and unanticipated roles. Anderson (1987) points out in her study on Indo Canadian and Greek women that many did not work outside of the home prior to coming to Canada. In conversations with women in both studies, we found women who had not worked outside the home as well as women who had not done house work before. Hence women are faced not only with the adaptation to a new society, but also their changing roles within that society. For many of the participants there was a constant state of negotiation between having to combine paid work with house work in the context of missing social support networks that were often available to them in their countries of origin. Brettell and Simon (1986, p.13) contend that "the apparent impossibility of combining both salaried employment and childcare has led to a decision by [some] women to sacrifice their roles as mothers in order to perform their roles as wives and economic partners". Two other participants in the *RPP* study corroborated the tension experienced, and the impact on their well being, for the amount of changes imposed by the new roles women are forced to take as recent immigrants:

In my country I worked (…) I have sitter [who] took care of my children, I never do something about housewife. I come to my house and my babysitter go away, I study, my husband work. The big difference then here, I come 11 months, I stay home, I do everything. Sometimes I am so nervous because I never stay[ed] at home. [I used to] go to work or [do] something else. Study, go to work, come back (…) Sometimes [when] I am not working, I am thinking … I can't stay like that.

For me ver-r-r-ry hard, I told you before, I never stay home. I don't have help, I have 2 children, the last 2 years difficult, children want to touch everything in the house. (…) my husband don't like to help me work. I clean, I cook, I like to see my house very clean, but sometimes it's not good for me. I do everything by myself, I do laundry, I go to shopping and clean the house, take care of baby, everything… But it['s] big, big difference. So, sometimes, I think I want to go back.

The participants of the study are enmeshed in the entanglements, or more accurately the disentanglement, of defining their space in their homes as well as in society itself. This has to be done while contending with personal experiences of patriarchal relations – the ones lived in their relations with their partners and children, brought from the culture of the country of origin, the ones perceived as the Canadian rules, as well as the systemic practices that are supported by Canadian society and that only slowly women start to identify due to their cultural novelty.

The anticipated social space of a "first world nation" clashes with the domestic, unpaid,

undervalued activities these women perform once in Canada. The transnational social space is one of comparisons in which people do not expect to live "worse, harder" lives in a "better" country. Rather they expect to be happier and healthier. The immigration process has long lasting effects on women's well being, impacting also on the level and quality of their participation in Canadian society. The mental health impact of loss of professional status, not finding qualified jobs, and the contact with the place of origin reminding them of whom they "used to be" puts strains on the self-esteem, as well women experience multiple, competing elements that constitute subjectivities that are difficult to articulate outside a transnational space.

P: I used to be happy, lively, but now something has changed, it's not the me I used to be at home.

M: Oh no?!

P: No, at all. First of all, I'm not, ah, doing a job I feel I should be doing. (…) So that's why I'm willing to start it, make sure that at least I get a job which will make me happy. So that rules my life. So I want to do something which I'll feel good about myself. So I'm no longer myself at all. I'm a different person totally. (…) So many changes, so it's not the me; I used to know myself as I am, but...*(GP)*

While immigration offers the dream of opportunities for all, unequal power relations and social inequalities exist within immigrant women's homes as well as society at large. The transnational social space of immigrant women is one of contrasts between distinct forms of gender inequities and a search for a social location within Canadian society. This process presents a quagmire of marginalization, resistance, inclusion and accommodation. The women in these studies struggled to define themselves beyond the narrow confines of a dominant discourse that reduces their multiple subjectivities to "immigrant" and being in a social space in between places gives them elements to orient their quest for social inclusion at the same time that could fuel their resignation to common place sexism.

Immigrant women as transnational health promoters

The lack of gender analysis of transnational social spaces silences and makes invisible the work done mainly by women. In our studies we found examples of women supporting the emotional well being of families living in distinct locations, fostering the healthy development of children through low cost food preparation, leisure activities, additional educational tutoring, among many other activities.

These roles do not seem, at first glance, particularly related to transnational health promotion. Many Canadian mothers could claim that they carry multiple roles. However, what makes these examples specific to transnationalism is that care giving and health promotion in this case are done in a transnational social space, where people's subjectivities are in between places and

women not only have to shape their own subjectivities in this context, but they produce health by supporting the process done by their children and partners (being them all together or living in distinct locations). Despite the outstanding versatility and resilience that such a task requires, this process is also an exhausting one. If this narrative somehow constructs immigrant women as "super women", it is because in part our findings emerged from narratives of strength, courage, and commitment (e.g. the participant who "couldn't get depressed because her children depended on her good mood to keep going"), but they also reveal the burden of immigration and care giving across national borders. As a participant in the GP study explained:

When you leave one life and you come to a new country, it's like you're starting a whole new process all over again. So it's like being a baby; you have to build from what you have, which is nothing. You came with nothing, and you have to be determined to be building from that nothing into something. And then, you know, besides not having anything, not knowing anyone, you have a – you have to come across certain boundaries that have been set there, like the immigration laws; the immigration, there are so many down sides that, you know, there is not much information provided for immigrants, especially immigrant women, on a whole (…) you have nobody to talk to, you have no place to turn, and you know, these things are not being advertised because as an immigrant woman, you know, some people look at you as nothing. You are required to be nothing, just a tool in a day's work or a tool to be used like food to cook, clothes to wash and that sorta thing. So it's – that's really different and it makes you different because you have nowhere else to turn.

Out of this process it is not surprising that, like in other contexts (Baines, Evans & Neysmith, 1998), transnational care giving and health promotion has a personal cost; caring for others and forgetting oneself results in burden that, in many cases, is manifested in psychosomatic symptoms. A participant in the RRP study reported that "…I had very good health arrival in Canada, very good health. And September I had report in hypertension and bleeding [in] my stomach, [I'm] very, very sick and for me [this is] very important".

However, for some immigrant women, the participation in a transnational caring circuit meant they too felt cared and appreciated and could deal with a more positive self-image and retain elements of their subjectivities from times they felt pleased about who they were.

In all these cases, the physical distance limits caring and health promotion and despite living in a transnational space, many participants needed help that required physical presence:

If I can talk with no problem, if I have… time to study and …get somebody to take care of my baby. I think maybe my life can be better.(GP)

Final remarks

Immigration turns many women into transnational health promoters and caregivers. Looking at

immigration, gender and health promotion from a transnational perspective, we could identify caring networks between countries, social support circuits and processes that contribute to the construction of the women's subjectivity as "immigrant" in co-existence with other subjectivities built in transnational social spaces. By shedding light into this phenomenon, we are indicating the complexity of the experience of immigrant women, as well as their resourcefulness and resilience. The transnational experience of these immigrant women reminds us that health has to be actively produced and that the well-being of families, communities and nations is also being produced in international networks of health promotion and care giving generated by women's labour.

This chapter also provides insights for gender studies because our empirical evidence shows that the negotiations of patriarchal experiences can only be understood in the context of class, race and other intersections. While for some women coming to a society that demands two workers to make a reasonable family earning is a distressful experience because they do not want to join the formal employment sector, for others becoming a housewife and not getting a job of equal status to what they used to have in their country of origin is particularly disturbing. In this context, we can think of a continuum of patriarchal relations that are manifested with distinct intensities in different regions or countries. Coming to live in an advanced liberal society does not necessarily translate into experiencing greater social equity.

The naturalised, gendered work performed by women happens transnationally because across national borders women work more to produce social well being. The politics of health promoting work for individuals and communities still remains a component of women's cultural identity (something attributed to them), many times a gratifying activity, a possibility for signifying people's existence and a form of power exercise and social relation. In addition, most men are very reluctant in trying new forms social participation, even when they are transnational.

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