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Embodying Inequalities: Globalization, Health and Foreign Domestic Care Workers

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Abstract

Globalization has impelled high rates of labour migration from south to north. In recent years, women who migrate to work in the private households of the global north as domestics or domestic care workers comprise a large percentage of this migratory flow. In this paper, I explore the narratives of foreign domestic care workers in Canada, predominantly women from the Philippines, to uncover how forces of globalization, experiences of displacement and unequal power relations are played out and lived at the level of the body. Foreign domestic care workers often speak of diffuse bodily pains and stress, locating the etiology of their complaints in the social world. I argue that the expression of these somatic complaints can be regarded as evidence of the impact of global forces on gendered bodies and represents the embodiment of inequality. Importantly when foreign domestic care-workers share this body talk with other care-workers, they are potentially able to deploy their discourses of suffering and sacrifice to enhance social solidarity and mobilize social support. These effects, however, cannot completely mitigate their complaints especially as care-workers who remain in the country for several years begin to report declining health status concomitant with their own stalled and declining economic mobility. As it is primarily concerned with identifiable and measurable health conditions, the slipperiness of the health concerns of foreign domestic care-workers evade the gaze of a global health agenda. As a result, we fail to take into account the full range of health impacts wrought by globalization.

Keywords: embodiment, body, gender, globalization, domestic labour, biomedicine,
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Introduction

Health concerns raised in the context of the Millennium Development Goals which currently inform the global health agenda include: combating HIV/AIDS, malaria, tuberculosis and other diseases, eradicating extreme poverty and hunger, working towards universal education, reducing child poverty, improving maternal health and promoting gender equality (McPherson, Gushulak, et al. 2007; WHO 2006). Despite voicing attention to social determinants of health, communicable diseases in the global South—particularly those which are presumed to pose a threat to the “have” portion of the earth— remain a dominant focus of global health while concerns are raised about lifestyle behaviours such as smoking, exercise, and diet among the residents of the global North belying a full embrace of a population health perspective (Hall 2006). Broadly brushed disparities in disease burdens North and South whereby conditions wrought by individual health behaviours that are said to predominate in the North are posed in opposition to a greater concentration of communicable diseases in the South are challenged by increased migration and population mobility. The movement of populations have heightened political and medical interests in securing borders against disease outbreaks such as SARS and avian flu while concomitantly trying to minimize interference in international trade (McPherson et al., 2007). However, as Fidler (2007: 244) notes: “Critical health issues such as women's health, the global spread of non-communicable diseases and the building of broad-based local and national public health capacities, receive insufficient attention and suffer from the fragmentation of public health and health-care systems caused by proliferating yet uncoordinated public and private health initiatives.” While communicable diseases, non-communicable diseases, health care and women’s health services are greatly deserving of attention, we need to examine the epistemological underpinnings of global health in order to proffer a critique that can ultimately enhance its efforts by making it more relevant to a diverse populace.

Importantly, we must acknowledge that global health is at its roots a biomedical construct that is informed by positivist notions that the body and its manifestations of disease are universal and knowable, isolated from social, political, and individual context and attributable to a single etiology (Freund and McGuire 1995; Rhodes 1990). The doctrine of single etiology reflects the dominant, monotheistic Western tradition wherein each

condition is bureaucratically organized and codified in a singular text the International Classification of Diseases whose disease labels signal the severity of the condition and outline paths of contagion, treatment recommendations, and serve to legitimate individual response expressed illness experience and behaviour (Hahn 1995; Kleinman 1995).

As numerous feminist theorists have also noted, the normative biomedical body is also based upon a normative, heterosexual and male body—a body that is contained, ordered and presumably devoid of the messy hormonal fluctuations that are thought to plague the something diminished, if beleaguered and more complicated, female body (Battersby 1999; Oudshoorn 1994).

How well then do these biomedical constructs of body and disease classification serve a diverse populace whose lives and conditions fall under the gaze of global health? In this paper which is I caution is a preliminary consideration, I suggest that global health, with its Western biomedical underpinnings, fails as well to address gendered and embodied health concerns that fall outside of the constructs of biomedical nosological categories. I will use the example of foreign domestic workers to offer that global health needs to re-direct its gaze from a focus on single etiology and nosology to include space to consider the consequences of embodied distress and to bring a gendered, body back into discussion and the global health framework.

Foreign Domestic Care Workers in Canada

Globalization has impelled high rates of labour migration from south to north. In recent years, women who migrate to work in the private households of the global north as domestics or domestic care workers comprise a large percentage of this migratory flow (Parrenas 2001). While Canada has been importing domestic workers for over a century (Arat-Koç 1997), recent neo-liberal turns in global economic/political agendas have undermined public spending such that care-work has been increasingly off-loaded onto private households, primarily women in private households, while public involvement in support programs for children, the elderly or persons with disabilities has declined or

disappeared, increasing the demand for in-home care-workers (Armstrong and Armstrong 2001; Bannerji 2004).

The latest iteration of Canadian domestic labour importation, the Live-In Caregiver Program (LCP) was instituted in 1992. Designed to address the needs of families who required in-home assistance caring for children, persons with disabilities or the elderly, the LCP allows those who participate in the program to apply for permanent residency status and eventually citizenship after working under the auspices of the programme for 24 out of 36 months (CIC 2006). Applicants to the programme must have a high school education, speak one of Canada's official languages, possess relevant experience or certification from a special caregiver training course, and have a bona fide job offer from a Canadian employer. In reality the vast majority are university educated and well over 90% are from the Philippines (Government of Canada 2005).

Through a series of inter-linking research projects, I have been working with foreign domestic care-workers in Canada. The voices of the women I am sharing in this paper are from two of these projects and come from women who were currently working under the LCP or who had completed their requirements and were making their way in Canadian society as permanent residents.

Live-in Caregivers

Francine was a physiotherapy student in the Philippines, now working as a medical secretary in Canada. She considers herself luckier than many other former live-in caregivers. But like others her dreams of returning to school are being set aside so she can continue to send remittances to family members back home. She talks about her health:

The job is distressful (sic), it gives you like too much worries and you think a lot and you start to have headaches and . . . sometimes every day *[laugh]* that I can't sleep during the – like I wake up early and then when you wake up you know you're gonna start to think again . . . like for example I'm really tired during the night and then if I am so stressed like even if I'm so tired out I'll wake up early and then my mind starts: "Go to the bed, go to the bed." My body wants to go to the bed, but my mind is like you know wondering and thinking, which is... yeah... not good.

Insomnia, headaches, undiagnosed body pains were all commonly cited as health problems among the women I interviewed. Their symptoms were often diffuse, migrating throughout their bodies and eluding the classificatory certainty of a definitive disease label, leaving them with little assurance about the nature of their complaints. As Willow, former teacher in the Philippines, told me:

There were times that I could not sleep, where I feel very painful here in my back affecting my breast, like that. I went to my doctor several times and he said, "You're okay, you're okay, no problem." But I think I am not okay, I said to my doctor: "I think I'm not okay. My breast is really painful, my right hurt, sometimes my left." "But that's okay, Willow."

These conditions were not limited to those who were still LCP workers or those who were attempting to secure their futures and those of their families after having completed the programme. Michaela was working in western Canada:

I think because of the emotional stress I got sick and I was hospitalized. I was just visit the hospital 'cause I [was] vomiting and [had] fever and I got something wrong with my eye something like that. I don't know because I am always in the house—in the house only—so I am not really go out with someone else and you can do anything that you want unlike compare in back home you really enjoy being [there], but here you have to stay for two years or more than that.

Tasha, a former ESL teacher and translator from the Ukraine, has been trying to navigate the bureaucracy of Citizenship and Immigration Canada to obtain the appropriate visa conditions that would allow her to attend post-secondary school full-time. She remarked:

I was sick like a few times I had a flu and I think I was coughing one winter so I went –oh I just was not feeling well. I guess I was maybe stressed with all the paper that it takes so long and I wanted to move on and do something. I was approved for the college for the full-time program study in August and they didn't let me because I didn't have papers so I just got very stressed and I thought that something wrong with my heart . . . and I talked to my employer so she made me an appointment in her doctor's clinic. I went there so I was sent to do all the tests and they came back – the results

came back and I was healthy, so I just realized that it was just maybe stress, I just got very stressed.

One focus group respondent residing in western Canada shared this observation:

I live in caregiver, the word “live-in” already is connoting or it implies already that you are in a box (laughs) right? So that “live-in” alone is already an implication of stressful life because you are not free. Not really free indeed . . . Yeah of course being in a box while you were not used to that, right would affect negatively your emotional health and because of the emotional health being negatively affected your physical health will also be affected.

Body Talk

These few voices offer but a glimpse of the somatic expression of the painful and constrained circumstances that this sector of the global workforce encounters. Living and working in the same space with little control over one’s environment while under the LCP, (control of course being key to good workplace health), vulnerable to personal, gender and structural violence, often downwardly mobile in terms of social if not necessarily economic status, and generally isolated from social support, these informants often complained of pains that eluded detection or validation through biomedicine and biomedical technology. While physicians were dismissive or nonplussed by their presentation of symptoms, live-in caregivers past and present readily understood the pains in the heart, breast, legs, or sleepless nights as linked to segregation from family, and other loved ones including children, spouses, lovers, and homelands. They linked their anxiety to their uncertain futures, to the seemingly impossible demands of being a dutiful daughter, wife and mother who on one hand is meant to stay home while on the other hand is heralded as saviour of her country’s economy (Parrenas 2001).

It is through our bodies that we experience, order and share the world (Spitzer in press) creating inter-subjective space where socio-cultural environments influence behaviour and our expectations of others (Young 2005). Embodiment is the inter-subjective ground of experience, an indeterminate field informed by perception and engagement with the world

yet suffused through the material, yet culturally constructed, entity of the body ((Csordas 1994, 1999; Spitzer in press).

The body speaks of its suffering, its alienation, and its strengths through the language of pain and perseverance reflecting the embodiment of inequality and adversity. Talk about the body can mean talk about everything (Davis 1997) and opportunities to share this talk of suffering with others is an important means of reaching out to others with similar experiences to elicit empathy, recall struggles and their strengths of will to overcome them, and to enhance social solidarity and facilitate social support (see also Coker 2004). The etiologies of the suffering are situated in the social world where complex webs of relationships from global forces to personal lives are linked and experienced at the level of the body. Deploying the language of stress allows sufferers to negate mind/body dichotomies and the reductionist, decontextualized approach of biomedicine in a manner that is comprehensible if not wholly accepted within the biomedical worldview.

Conclusion

To borrow from Arthur Frank (1990), it is perhaps time once again to “bring the bodies in” to global health theory and practice. Bringing the body back into the focal inquiry, decenters the Western lens of global health by focusing on suffering including social suffering of those who bear the brunt of globalization, it defies Western culture bound nosologies and lets the subaltern speak to the way in which their suffering is related to broader social/political context that considers among other things, the impact of policy on the body and the manner in which intersecting social markers of gender, ethnicity, socioeconomic status, migration status, etc., are experienced simultaneously. Attempts to contain symptoms and complaints in the context of the physical, knowable, discrete body are grounded in once again in male notions of the body while women’s bodies appear leaky, messy, and disordered by comparison (Battersby 1999).

Foreign domestic care workers often speak of diffuse bodily pains and stress, locating the etiology of their complaints in the social world. I have suggested that the expression of these somatic complaints can be regarded as evidence of the impact of global forces on gendered bodies and represents the embodiment of inequality. In the example I shared, women predominantly from the Philippines, allow us to uncover how forces of

globalization, experiences of displacement and unequal power relations are played out and lived at the level of the body. As it is primarily concerned with identifiable and measurable health conditions, the slipperiness of the health concerns of foreign domestic care-workers evade the gaze of a global health agenda. As a result, we fail to take into account the full range of health impacts wrought by globalization. While it is imperative to continue to work on the mitigation and elimination of major communicable diseases, we need as well to ask: Whose bodies count in global health?

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