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## Pathways between under/unemployment and health among racialized immigrant women in Toronto

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### ABSTRACT

**Objective.** We sought to document pathways between under/unemployment and health among racialized immigrant women in Toronto while exploring the ways in which gender, class, migration and racialization, as interlocking systems of social relations, structure these relationships.

**Design.** We conducted 30 interviews with racialized immigrant women who were struggling to get stable employment that matched their education and/or experience. Participants were recruited through flyers, partner agencies and peer researcher networks. Most interviews (21) were conducted in a language other than English. Interviews were transcribed, translated as appropriate and analyzed using NVivo software. The project followed a community-based participatory action research model.

**Results.** Under/unemployment negatively impacted the physical and mental health of participants and their families. It did so directly, for example through social isolation, as well as indirectly through representation in poor quality jobs. Under/unemployment additionally led to the intensification of job search strategies and of the household/caregiving workload which also negatively impacted health. Health problems, in turn, contributed to pushing participants into long-term substandard employment trajectories. Participants' experiences were heavily structured by their social location as low income racialized immigrant women.

**Conclusions.** Our study provides needed qualitative evidence on the gendered and racialized dimensions of under/unemployment, and adverse health impacts resulting from this. Drawing on intersectional analysis, we unpack the role that social location plays in creating highly uneven patterns of under/unemployment and negative health pathways for racialized immigrant women. We discuss equity informed strategies to help racialized immigrant women overcome barriers to stable work that match their education and/or experience.

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## Introduction

Toronto is one of the most multicultural cities in the world with almost half of its residents born outside of Canada (Statistics Canada 2011). Despite this, immigrants – particularly women, as well as those from recent immigration and racialized backgrounds<sup>1</sup> – continue to experience the worst labour market conditions and outcomes. They are more likely to be unemployed or underemployed in jobs that do not reflect their education or experience and that are characterized by low skills, low pay, high risk and precarity (Fuller and Vosko 2008; Premji et al. 2010; Law Commission of Ontario 2012; Premji and Lewchuk 2013; Reitz, Curtis, and Elrick 2014; Statistics Canada 2014). For example, 2006 Census data show that among recent immigrants,<sup>2</sup> 28% of men and 44% of women are underemployed, while the proportion among established immigrants is 21% for men and 29% for women – compared to just 10% for men or women who are Canadian-born (Galarneau and Morissette 2009). As well, analysis of Ontario level data from Statistics Canada’s 2008 Survey of Labour and Income Dynamics shows racialized and gendered patterns of over-representation in precarious forms of employment. For example, it shows that while racialized women represent 11.8% of all workers, they constitute 18.4% of part-time, temporary employees (Noack and Vosko 2011). The labour market barriers that immigrants face are well-known and include language barriers, lack of professional networks, restrictive professional accreditation systems, and discriminatory employer practices, all of which operate along racialized and gendered lines (Ng 2002; Man 2004; Teelucksingh and Galabuzi 2007; Creese and Wiebe 2012). Immigrant women additionally face social barriers to decent employment that relate to household gender relations (e.g. heavy household/care-giving workload, lack of affordable childcare, unsupportive spouse, etc.) (Premji et al. 2014).

Under/unemployment negatively impacts the health and well-being of workers and their families in multiple and complex ways. Unemployment has been found to lead to poor mental and physical health through pathways that include lack of income, loss of status and self-esteem, reduction of physical and mental activity, and unhealthy behaviours and coping strategies (Bartley 1994; Jin, Shah, and Svoboda 1995; Murphy and Athanasou 1999; McKee-Ryan, Song, and Kinicki 2005; Paul and Moser 2009). Similarly, objective and subjective measures of underemployment have been linked to poor general mental and physical health (Smith and Frank 2005; Dean and Wilson 2009; de Castro, Rue, and Takeuchi 2010; Chen, Smith, and Mustard 2010), chronic diseases (Friedland and Price 2003; Peter, Gässler, and Geyer 2007), occupational injuries and illnesses (Kerr et al. 2001; Premji and Smith 2013), and adverse neonatal health (Meyer, Warren, and Reisine 2010). While pathways vary according to the outcome examined, underemployed individuals may find their health negatively impacted by the very experience of underemployment (e.g. reduced job satisfaction resulting in poor mental health (Chen, Smith, and Mustard 2010)), as well as by their consequent representation in low-skills, low-paid, high-risk and precarious jobs, which carry their own risks for health. For example, precarious employment, which broadly refers to high levels of job insecurity, has been shown to negatively impact health through mechanisms that include greater exposure to risks; fewer protections and opportunities for training; absence of benefits; lack of compliance with and enforcement of legislation; limited agency; and work-life conflict (Quinlan, Mayhew, and Bohle 2001; Chaykowski 2006;

Benach and Muntaner 2007; Malenfant, LaRue, and Vezina 2007; Lewchuk, Clarke, and De Wolff 2011; Access Alliance Multicultural Health and Community Services 2012a).

Importantly, research has shown that social location modifies the relationship between work – or absence of work – and health, as some groups are more vulnerable to adverse effects because of systematic differences in life experiences and in access to coping resources (Béland, Birch, and Stoddart 2002; Premji 2014). With respect to under/unemployment, there is some evidence that effects on health vary by gender (Akhavan et al. 2004; Artazcoz et al. 2004; Ro 2014), as well as by migration and racialized status (Beiser, Johnson, and Turner 1993; Meyer, Warren, and Reisine 2010). However, qualitative studies in this area are lacking, and so the ways in which pathways are influenced by these markers of social location are poorly understood. Developing this knowledge is important as it can help increase our understanding of the role of labour market experiences in the production of health inequalities, as well as ensure that the specific issues of the less powerful or visible are given proper attention. Specifically, it can help give voices to immigrant women, particularly those from racialized backgrounds, which have largely been missing from policy framing and public debates about labour market issues in Canada. Our study therefore sought to examine pathways between under/unemployment and health among racialized immigrant women in Toronto while exploring the ways in which gender, class, migration and racialization, as interlocking systems of social relations, structure these relationships.

## Methods

This study was led by Access Alliance Multicultural Health and Community Services, a non-for-profit organization that provides community-governed primary health-care services to disadvantaged immigrants in Toronto. Since 2006, Access Alliance has been leading a multi-phase research agenda on the labour market experiences of immigrant and racialized communities (Wilson et al. 2011; Access Alliance Multicultural Health and Community Services 2012a, 2012b). The study we describe builds on this body of research by examining the experiences of racialized immigrant women who have difficulty securing stable employment that match their education and/or experience. In a previous article, we reported on the barriers to decent employment in this population. The present article examines the ways in which underemployment and unemployment, which are deeply intertwined in our population, impact physical and mental health. The study brought together an interdisciplinary team of academic partners, community agency partners from the settlement and employment sectors, and racialized immigrant women. In line with community-based research principles, Access Alliance trained and engaged seven racialized immigrant women as peer researchers in the study. Peer researchers each received over 40 hours of training in research design, ethics, recruitment, data collection and analysis, and were involved in all aspects of the research. The team gathered in three collaborative meetings to jointly develop the research design and questions. Ethics approval was obtained from McMaster University's Research Ethics Board.

We recruited for interviews 30 racialized immigrant women who were struggling to get stable employment that matched their education and/or experience. That is, at the time of the interview, despite their best efforts, participants were unemployed or employed in jobs characterized by insecurity, low skills and low pay, and that did not

reflect their qualifications. Since we were interested in women who were actively participating in the labour market, we recruited participants who were not dependent on social assistance in a long lasting manner. In order to ensure all participants had sufficient time to actively participate in the Canadian labour market, we recruited participants who had been in the country for at least two years. We further targeted women who spoke Arabic, Dari, Nepali, Sgaw Karen or Somali since these were the languages spoken by our peer researchers. Women from other language groups could also participate in the study as long as they could demonstrate intermediate-level fluency in the English language. Participants were recruited through posted flyers (translated in relevant languages), partner agencies, peer researcher networks, and through snowball sampling.

We conducted in-depth interviews with the participants. The interviews took place at the offices of Access Alliance, which has three locations across the city of Toronto. The length of the interviews varied between 90 minutes and 2.5 hours. Participants were given an honorarium of \$45 for their participation and signed consent forms which were available in English and the five target languages. Most interviews (21) were conducted in a language other than English. All interviews were audio recorded and transcribed, with those conducted in a language other than English translated as appropriate. Research team members read a representative number of transcripts in order to develop a master coding framework that sought to capture important themes. Transcripts were then coded using NVivo software. The team periodically reviewed new themes that emerged during coding, and back-coded to all transcripts any that were relevant to the study's goals. Coded thematic summaries were then jointly analyzed using a collaborative data analysis process developed by Access Alliance. In addition, the team conducted a literature review and policy scan to map current evidence and policy directions related to the work and health of racialized immigrant women.

Our study was informed by intersectionality theory. This framework, which originates in the work of African-American feminist scholars (Crenshaw 1989; Collins 1990), 'moves beyond single or typically favoured categories of analysis (e.g. sex, gender, race and class) to consider simultaneous interactions between different aspects of social identity ... as well as the impact of systems and processes of oppression and domination' (Hankivsky and Cormier 2009, 3). Accordingly, intersectionality theory rejects the notion that one dimension of identity takes a priori precedence over others, and rather recognizes that salient dimensions differ according to context (Yuval-Davis 2006). It avoids using an additive approach, focusing instead on the interdependence of social locations and its impact on experiences. Furthermore, intersectionality emphasizes the role of multi-level processes and systems by examining how social location and structural forces interact to shape the production of inequalities (Hankivsky 2012). It has been argued that research on social inequalities in health can benefit from intersectionality theory, as the focus thus far has largely been on gender as the primary source of social differentiation, obscuring the issues and priorities of many vulnerable women, including racialized women (Hankivsky et al. 2010). Our study therefore seeks to contribute to emerging health research on diverse groups by examining how gender, class, migration and racialization intersect with each other to create varied pathways between work and health.

## Results

### *Participants' characteristics*

Participants were at least 30 years old and 24 out of 30 were between 30–49 years of age. Most (24) had partners and 17 had children less than 18 years of age. In most cases, the entire immediate family was living in Toronto with the participant. Most of the participants (21) had a university degree. A plurality of participants was from South Asia (10), although there were 13 countries of origin in total. Participants were evenly distributed in terms of newcomers, medium term immigrants and longer term immigrants. Nine participants came through one of the refugee streams (Government Assisted Refugees or refugee claimant). Five of the participants were principal applicants in their family's immigration application to Canada through the Federal Skilled Worker program. A full overview of the participants is available in [Table 1](#).

### *Participants' labour market experiences*

Participants described numerous barriers to decent employment. They described migration-related barriers that included the non-recognition of foreign credentials by licensing bodies and employers, racialized discrimination during job search or within workplaces, communication and linguistic difficulties, work restrictions based on citizenship or immigration status (e.g. restrictive work permits for refugee claimants), information and access barriers about services, and limited professional networks. These

**Table 1.** Demographic profile of study participants.

Variable	<i>n</i> ( <i>N</i> = 30)
<b>AGE</b>	
30–39 years	10
40–49 years	14
50–59	6
<b>Married or in a relationship</b>	24
<b>Has adult children</b>	7
<b>Has children under 18 years of age</b>	17
<b>Has a university degree</b>	21
<b>REGION/COUNTRY OF ORIGIN</b>	
West Central Asia/Middle East (Afghanistan and Iran)	4
China and South East Asia (Burma and Philippines)	7
South Asia (Bangladesh, Nepal and Pakistan)	10
Africa (Somalia, Sudan and Sierra Leone)	5
Central and South America (Mexico and Uruguay)	3
Europe (Albania)	1
<b>LENGTH OF STAY IN CANADA (2011 as reference)</b>	
2–5 years	11
6–10 years	9
11+ years	10
<b>IMMIGRATION STATUS UPON ARRIVAL</b>	
Skilled worker/economic class (dependent)	8
Skilled worker/economic class (primary applicant)	5
Government assisted refugees	5
Refugee claimant	4
Family sponsored	4
Live-in caregiver	2
Other	2

barriers manifested themselves in unique and pronounced ways at the intersection of migration, gender and racialization. For example, the two participants who came through the live-in caregiver programme, a federal programme geared at bringing women from other regions of the world – particularly the Philippines – to serve as low-cost ‘flexible’ care workers in Canada, talked about the many difficulties they encountered in meeting the programme requirement to qualify for permanent residency and in attempting to transition to stable professions. Micro-level barriers were similarly experienced at the intersection of multiple social locations. For example, women from the Muslim community spoke about how wearing the hijab exposed them to frequent acts of racialized discrimination during the job search process and in workplace settings. In fact, prevailing societal attitudes about acceptable jobs based on gender and racialized status served to channel participants into low-level occupations that were highly feminized and racialized. For example, ‘Gemma’, a 38-year-old from the Philippines, gave the following example of this process at play:

I remember when I was asking someone from the bank how did you apply, because I knew that she was also an immigrant, and she was saying that oh you’re better in the care giving profession because you’re Filipino. I was like, okay. So it’s like putting a label on me that you cannot work for this kind of field.

Some participants also experienced tremendous gender-specific difficulties and tensions during the migration process and through the immigration application process which in turn negatively impacted their labour market outcomes. For example, some participants were in abusive spousal sponsorship arrangements that reinforced their dependent status and impacted their ability to look for or maintain employment. Participants additionally described social barriers to decent employment that reflected their position as low income racialized immigrant women. These included high loads of household and caregiving work, social isolation and lack of support networks, unsupportive male partners, lack of affordable childcare, and limited mobility (e.g. not being able to commute to certain areas). They also lacked access to services/programmes and economic assets to overcome these barriers. Accordingly, class weighed in heavily in terms of how these barriers manifested themselves and were addressed.

As a result, participants’ labour market experiences were marked by difficulties finding work. They typically reported multiple short periods of employment – often balancing various part-time jobs – and lengthy periods of unemployment between jobs. When participants found employment, they worked in jobs that were low-skilled, low-paid and insecure (e.g. work that is commission-based, for a temporary agency, on a short-term contract, on call, involuntarily part-time, etc.). Their jobs were also characterized by poor working and employment conditions. For most participants, these conditions were markedly different from what they had experienced prior to migration. For some, the jobs they held in Canada were very marginally related to their education and/or experience. For example, those from teaching and health-care professions were working as daycare assistants or personal support workers. Others faced even worse job-skill mismatch. For instance, Nazanin, a 44-year-old trained doctor from Iran, was juggling minimum wage jobs as a cleaner and fast food worker. Other participants reported working in establishments such as discount stores, coffee shops and clothing factories. In order to supplement their income, many had or were engaged in informal income



generating activities (e.g. babysitting, cleaning and cooking). Most participants reported that their spouses were also employed in jobs that were gendered and racialized, unstable, and that did not match their education and/or experience (e.g. taxi driver). A minority of longer term immigrants reported improvement in employment over time, though they remained in low-paid, front-line occupations. For example, Yamu, a 41-year-old from Nepal, initially worked as a housekeeper and at a fast food restaurant. After obtaining a degree in early childhood education, she found employment as an assistant at a childcare centre and had been there for 2.5 years at the time of the interview. In many other cases, however, the employment situation did not improve with increasing length of time in Canada.

### ***Pathways between under/unemployment and health***

Participants' labour market experiences impacted their health and that of their family in various ways. They decried how their difficulties finding work, specifically the lack of recognition of their skills by employers, made them feel devalued. Interestingly, a number of participants who spoke about this lack of recognition defined their skills in gendered and age-related ways:

I'm an excellent cook ... I do crafts, I know how to teach how to knit, I know how to crochet, I know how to do stained glass ... These women, my generation, we are disappearing ... People that are in charge should give us a chance to look with different optical, different glasses that we could be very valuable and very helpful in many different ways. (Lucia, 54 years old, from Uruguay)

Participants' social location as immigrants shaped their feelings in relation to their difficulties finding work. They described developing an inferiority complex relative to Canadian-born workers, as illustrated by this quotation from Farah (45 years old) who was an English professor in Pakistan:

... trouble finding a job of course affects health. You feel a dollop of inferiority complex that affects your level of confidence in life. And you think you are useless, maybe here the people they are more qualified, more competent. We are living in that part of the world and we are not that compatible with this environment.

Negative feelings about the job search process extended to participants' family members. For example, Rupa, a 47-year-old who was an elementary school teacher in Bangladesh, had to conceal her difficulties finding employment from her 16-year-old daughter because, as she stated, 'when I share with her she will also get upset, why her mom will do so many household work and try for jobs and run here there'. Frequently unemployed, participants described how being unproductive, dependent – on government supports or relatives – and 'trapped in the house' negatively affected their sense of self. Their unemployment compounded the social isolation they experienced as a result of the migration experience:

I have emotional problem ... I think about I'm alone here, I don't have any family, I don't have any relatives here, I don't do a job, I don't go outside, I'm not with my friends. This affect my health ... If I find a job I think I would get better. I will be busy with my job. I forget everything. (Afsoon, 54 years old, from Afghanistan)



The lack of job and income security participants experienced at the individual and household levels affected their health and that of their family in multiple ways, including the inability to pay rent and bills, buy clothes, food, medication, and save for emergency situations or old age. For example, Zaria, a 35-year-old from Sierra Leone, described the following:

I can't afford good meals ... When there is not enough in the house we keep all what's there for my son and we barely manage ... If there's vegetables, we keep it for him. And we will manage whatever is in the house because we are adults we don't think we need those things to grow but then we need it to improve our health because we can't be living on an unbalanced diet.

Many participants also had financial responsibilities overseas, having to support the health or education of relatives. This further stretched their financial resources and weighted heavily on their minds:

Sometimes they [kids- 2 sons who live in Bangladesh] demand; 'give me this'. My kids, just I give them. So nowadays I'm not talking like before. If they want something, I can't give them that. So I'm just worried, just taking some distance [later comments that she is not calling them as much as before because she can't explain her situation to them]. (Reshmi, 43 years old, from Bangladesh)

Health impacts relating to insecurity were compounded by the fact that participants' jobs rarely provided them with extended health-care benefits (e.g. prescription drug insurance, dental benefits). Most participants had minor children, and the guilt they felt about not being able to provide necessities for them was a recurring theme:

And it came at a point when my son was being sick like every day. I needed medication for him. We went to [major hospital]. His medication, one tablet was 25 dollars ... So the 15 tablets or so that was prescribed to him was three hundred and something, I didn't have it ... So each time he gets sick, I feel depressed, I feel guilty that I didn't give the medication he needs because I cannot afford it. (Gemma, 38 years old, from the Philippines)

In addition, participants' jobs provided them with few, if any, protections. Namely, their jobs seldom allowed them to take sick days, either because employers did not allow it or because sick days were unpaid. For example, Guadalupe (32 years old, from Mexico) explained that she was unable to take time off from her work at a Laundromat while she was struggling with breast cancer because her manager told her no one was available to replace her.

The jobs participants obtained were often risky, exposing them to physical, ergonomic, biological and/or chemical health risks. Their jobs, and social location as racialized immigrant women, also placed them at risk of particular psychosocial hazards such as excessive expectations, disrespectful attitudes, and expressions of racism and sexism on the part of employers or colleagues. A number of participants also noted the risky nature of the jobs held by their spouses and other male members of their communities, and their resulting injuries in light of their deskilling:

When they come here they don't get the proper job with their skills, the job match, actually it is mismatched. So to support the family they try to do something where they are not fitting, already physically, mentally and by skills. Then what happens, lots of injury happening and they become sick, emotionally they break down ... and they feel very low. (Sadia, 47 years old, from Bangladesh)

However, when relating their own poor working conditions, participants mostly noted the impacts on their mental health:

... he [supervisor at a major fast food chain] just ignore my voice ... How he behaved to me was, I felt really rude and sometime I went to the corner and cried and I talked with owner ... and she said because of, because this working environment is like this, if you don't, if I don't like job you can quit. (Yamu, 41 years old, from Nepal)

Poor employment conditions further negatively impacted participants' mental health. This is illustrated by Lucia's account of the impact of her problematic work schedules:

Well at that work I find myself with shift work, 24/7 because it's at the airport ... All the holidays, all the special moments in the family I found myself working ... I got sick, I really got sick. I had a panic attack at the airport and I guess it's due to the stress that I was going through. And then the doctor suggest to me that it was too much for me, all this work and the hours and the shift and nights and that stress because of my family, the problems. I could not get the hours that I wanted to. (54 years old, from Uruguay)

Work hour discordance between spouses was a particularly salient issue given that a majority of participants had minor children and was living with spouses who also experienced irregular schedules. This discordance resulted in reduced family time, communication gaps, relationship tensions and anti-social behaviours. Crucially, it limited the household's ability to talk about and address pressing economic and health issues. Working at odd hours, and/or in unfamiliar locations, also led to concerns about potential sexual violence, an inherently gendered phenomenon. This fear was noted by many participants, like Zaria (a 35-year-old from Sierra Leone):

The worst thing is when they get me the key to the big office I come there on the weekends and I am scared to death because there's nobody there, nowhere, and it's in an area where, it's not a residential area ... So even though I am afraid, I walked down that road ... And then go into the office and close the door, and when a box falls down my heart is going to just jump out, because I'm thinking that somebody's going to attack me in the office in my little storage.

In addition to problematic schedules, in speaking about their poor employment conditions, many participants mentioned long working hours and their resulting fatigue and inability to find time to exercise. They spoke about how their extended travel times (1.5–2 hours in each direction) added to their fatigue, particularly as many of their jobs – as front-line positions in feminized sectors – required them to stand all day:

The places was too far for me ... And it affect my foot. Because ... I would stand, whole day. One day I sit down they complain. Next time they call me, the lady sent me to the daycare, 'Don't sit down, we don't sit down. We should stand up all day'. But I can't, 2 hours I went to work, 2 hours I come by bus. 7 hour I worked. It affect my foot, that's why I quit the job. (Afsoon, 54 years old, from Afghanistan)

Interestingly, our study showed that under/unemployment also impacted health through the intensification of job search strategies and of the household/caregiving workload. In an effort to secure decent employment, participants used a wide range of job search strategies. Initial search strategies were generic (e.g. applying for jobs online), and training and investments were limited to attending resume clinics and workshops about Canadian workplace environment and etiquette. These strategies at best resulted in jobs that were low-skilled, low-paid and insecure. In response to their experiences of under/

unemployment, many participants shifted to more focused and intensive strategies that sought to target migration-related employment barriers. These strategies included skills training, upgrading their education or getting a new degree, and volunteering to gain ‘Canadian experience’ and expand their social networks. These strategies were gendered in that participants trained in areas like catering, obtained degrees in fields such as social work and early childhood education, and volunteered in the gendered and racialized non-profit community or settlement agency sector in front-line positions. These latter strategies required more time, effort and in some cases additional expenses, and resulted in frustration at having to ‘start over’ and at generally failing to result in decent employment. For example, one internationally trained physician mentioned that she had been volunteering for over two years at a hospital, doing what she called ‘disrespectful work’ as a patient escort. Many had to accommodate these resource and time intensive job search strategies while juggling one or more jobs, which added to their anxiety and exhaustion. For example, Azin, a 45-year-old who was a doctor in obstetrics and gynecology in Afghanistan, related how going through numerous recertification exams was causing her sleep issues:

I cannot sleep at night, I think all night, and I see nightmares, bad, bad things. Every time I go somewhere, to do examine and I failed or I don’t know too many people doing the exam ... some people tried to cut me with a knife, like this kind I see in nightmares. And I see, I wake up and I think why I see this kind of things and, I have some drop and I take this in water. Sometimes it help me and sometimes not.

The intensification of job search strategies also impacted participants’ family members, and this was particularly the case for participants with younger children. For example, to make her more competitive in the labour market, Gemma (38 years old, from the Philippines) returned to school and started volunteering. She explained how her elevated workload and reduced family time impacted her young son:

Especially when I went back to school is he’s constantly asking for attention ... One time I was yelling at him last weekend and I asked him, I’m so tired and I’m also sick and I told him ‘What do you want from me. Tell me, I know you can speak now, tell me, what do you want to say to mommy?’ And he was saying that ‘I just want you to hug me’. Because he was saying that it seems that, since I was always busy ... I don’t play with him anymore, and he said ‘you don’t hug me as much as you did before’. So at 3 years old oh my goodness, it’s like wow ... I feel so guilty.

Under/unemployment also intensified participants’ household and caregiving workload. Most participants reported doing most of their household’s domestic work. Reasons for this gendered division of domestic labour were varied and complex and included cultural, socioeconomic and structural factors (e.g. low income coupled with lack of affordable childcare). The work and health of participants’ spouses also contributed to this workload. Many women mentioned that their spouse was either too busy working multiple jobs and/or too exhausted to help with the household and caregiving work, and several women spoke about the added responsibility of having to look after a spouse who was experiencing a recurring illness or workplace injury. More generally, participants described providing emotional support to spouses and/or children as the family faced social, economic and health hardships. The intensification of household and caregiving functions, fuelled by under/unemployment and occurring within the post-migration

context of a diminished social support system, contributed to participants' exhaustion and sleeplessness:

As soon as I got home I starting to do the things for cooking, cleaning doing everything. [Interviewer asks: 'And you were working 12 hours too?' And participant replies:] Yes, from 8:00 a.m. until sometimes 7:00 or 8:00 in the evening ... until 1:00 a.m, I was taking care of the other things. Like a robot. (Arlinda, 54 years old, from Albania)

Yeah lots of stress, I got depressed and I went to doctor, I could not sleep because everything is different, no extended family here, only we four are here and then, and the main thing is my mom was not here ... So everything is on me. (Yamu, 41 years old, from Nepal)

Accordingly, in describing their multiple household/caregiving responsibilities, participants often spoke in gendered ways of self-sacrifice experienced in terms of their health, education and/or employment:

I deprived myself to be the woman that I could be in the workforce, just to keep the family together, ironically. I choose that to keep everybody happily together. And at the end, it didn't work, so, it affects me emotionally a lot, a lot. (Lucia, 54 years old, from Uruguay)

While participants talked about the various dimensions of their experiences in relation to their health, they also talked about the totality of their experiences. Many participants claimed that their under/unemployment and associated experiences caused their health to suffer after coming to Canada. For example, Anika, a 39-year-old physician in Bangladesh now working as a personal support worker, related the following:

Because when I came first, after one and a half years when I started to realize the environment, the future, I became stressed. For that reason I think I got, suddenly I had some neck pain or something. I went to the doctor and he said my blood pressure was way high at the time. So he did all the investigations and since this I'm taking my medication for blood pressure.

Accordingly, under/unemployment, through multiple pathways, resulted in a range of physical health impacts (e.g. unhealthy weight gain and sleep deprivation), mental health impacts (e.g. lowered self-esteem) and/or chronic health impacts (e.g. high blood pressure, heart disease, diabetes and chronic pain). These health problems in turn diminished participants' labour market engagement, as they talked about feeling disempowered to look for jobs in their field and concerned about their ability to find or keep employment even in the low-skill, low-wage sector.

## Discussion and conclusions

Previous research has shown that under/unemployment negatively impacts health (Bartley 1994; Smith and Frank 2005) and that effects vary by gender, migration and racialization status (Beiser, Johnson, and Turner 1993; Akhavan et al. 2004; Artazcoz et al. 2004; Meyer, Warren, and Reisine 2010). Our study provides needed qualitative evidence on the everyday level pathways. Specifically, we described how under/unemployment negatively impacted the physical and mental health of participants and their families directly, for example through social isolation and frustration, as well as indirectly through representation in poor quality jobs – jobs that were low-paid, lacked benefits, and were characterized by poor working and employment conditions. Importantly, it considered activities

outside of paid labour not as separate from it but as directly influenced by it. A handful of studies have documented racialized immigrant women's multiple and often concurrent strategies in response to underemployment and precariousness, both in the labour market (Ng et al. 2006; Cardu 2007; McCoy and Masuch 2007) and in the household (Creese, Dyck, and McLaren 2008). Our study adds to this literature by documenting how under/unemployment, experienced at the individual and household levels, resulted in the intensification of job search activities and of the household/caregiving work, which carried their own risks for health.

Our study also highlights ways in which these labour market experiences may disproportionately or differentially impact racialized immigrant women. Compared to other groups of workers, racialized immigrant women are disproportionately found in – and therefore impacted by – under/unemployment because of powerful migration-related and social barriers to decent employment. While many of these barrier are cross cutting factors that may also affect racialized immigrant men or Canadian-born non-racialized women, their manifestation is unique among racialized immigrant women and their intersection may result in them experiencing these barriers more acutely and persistently. In addition, racialized immigrant women may also be differentially affected by under/unemployment. In our study, participants were found to experience particular types of risks as a result of their labour market conditions. For example, they worked in jobs and trained and volunteered in fields that were highly feminized and racialized and that exposed them to risks, such as prolonged standing, which are disproportionately found in these occupations (Messing et al. 2004). Within jobs, their social location also exposed them to risks, such as racism and sexism, which may not be experienced by other groups of workers (de Castro, Fujishiro, and Jose Oliva 2006). It also contributed to their involvement in multiple and particular types of job search activities – again in fields that are feminized and racialized – and to their heavy household and caregiving workload, which carried their own risks for health. Even when participants faced the same exposures as might be experienced by other under/unemployed individuals, their social location modified the impact on their health. For example, fear of sexual assault, sleeplessness and guilt were intrinsically gendered responses to labour market conditions (Krishnan and Collop 2006; Etxebarria et al. 2009). Migration and racialization also modified health impacts. For example, participants described how the isolation and frustration they experienced as a result of being under/unemployed were amplified by the loss of social networks and the deskilling they experienced as a result of migration and discrimination. Similarly, the stress associated with financial hardship was heightened by their responsibility for minor children and relatives overseas. Health impacts may therefore be experienced differently in this population, or more intensely because of the intersection of multiple social disadvantages and associated stresses. Combined with racialized immigrant women's overrepresentation in under/unemployment, these dynamics result in a disproportionate or differential health burden for this population.

It is important to note that racialized immigrant women are a heterogeneous group and that their experiences are unevenly shaped by factors such as class, education level, age, immigration stream, official language fluency and support from male members of the household. Feminist theories of intersectionality have proposed that dimensions of social location need to be understood as interlocking systems that structure individual and group experiences, and result in highly uneven patterns of inequalities. Consequently, understanding one category of oppression necessitates understanding of how it intersects

with other categories of oppression (Zinn et al. 1986; Collins 2000). Our study supports this perspective as it found that the complex and uneven experiences of under/unemployment, and associated health impacts, could best be understood by paying close attention to the intersection of gender, migration, racialization, as well as to class and age. In fact, the pathways which we identified differ in many ways from those found in another study of the health impacts of under/unemployment conducted among highly skilled immigrants to Ontario who were mostly men (72%). Pathways in this study included lack of income, loss of skills and status, family pressures, high stress levels and strenuous working conditions (Dean and Wilson 2009). However, as our analysis also demonstrates, and as some scholars have argued, a nuanced understanding of the interlocking role of social locations and structures of power/privilege is needed as particular dimensions of identity may take heightened importance over others in particular contexts (Nash 2008). This was evident in our study as, in different contexts, the roles of gender, migration or racialization took on varying importance. Taken together, these everyday experiences can help us better understand the total and complex experiences of work or absence of work and their associated health burdens among marginalized populations.

Our results add to the growing evidence on the ‘healthy immigrant effect’ in the Canadian context. This body of evidence posits that immigrants’ health is generally better than that of their Canadian-born counterparts, but deteriorates after arrival (McDonald and Kennedy 2004; Newbold 2006). In fact, rates of decline in self-reported health among immigrants are particularly high for women and racialized individuals (Newbold 2005; De Maio and Kemp 2010; Kim et al. 2013). Current evidence on the causes for health deterioration facing this population has identified multiple intersecting determinants including labour market conditions, discrimination, language barriers, information and service access limitations, poverty, and social isolation. Our study provides qualitative insights on how under/unemployment contribute to this process for both recent and longer term immigrants. Our findings captured the immense health burdens that participants experienced as a result of their multiple activities and responsibilities, health burdens which manifested themselves at both the individual and household levels. These health issues in turn contributed to participants’ long-term, unsatisfactory employment trajectories. Further research is required to better understand the reciprocal relationship between work – or absence of work – and health.

## Recommendations

Intersectionality moves beyond individual-level causes and ‘blame the victim’ approaches to consider multi-level root causes for inequalities. As Hankivsky explains, this reframing is necessary for creating responses that address not only the effects of inequalities but also their underlying causes (2012). Accordingly, our findings underscore the need for intersectional and equity based policy actions to enable immigrant women to achieve stable, decent employment. Currently, most employment and settlement services for newcomers are focused on generic job search services (e.g. job boards), resume clinics, Canadian workplace readiness/etiquette workshops and official language instruction classes (Allan 2010). Study participants highlighted that in spite of exhaustive use, these employment/settlement services did not help them find stable, decent employment in their field. Previous research by Access Alliance suggests that some of these generic employment/settlement



services may be streaming immigrants into low-wage, low-skill jobs marked by high precarity (Access Alliance Multicultural Health 2012). Furthermore, as Ng and Shan argue, seemingly neutral programmes 'are deeply implicated in (re)producing and maintaining the gendered and racialized segregation of the Canadian labour market' (Ng and Shan 2010). This process occurs as employment and settlement services, through the reinforcement of discourses of suitable jobs based on gender, racialized status and class, effectively channel immigrant women into occupations that are feminized and racialized (e.g. settlement services, childcare, etc.). Policy and funding formula need to be reformed to expand employment/settlement services with proven track records of linking immigrants to well-paying, stable jobs in their professions (e.g. professional bridging programmes, paid mentorship programmes). Employment and settlement services also need to be made more sensitive with tangible goals and indicators geared at overcoming inequalities that immigrant women face in terms of employment outcomes. Another vital solution to promote employment security is to introduce employment equity policies at the provincial and municipal levels in Canada, building on federal employment equity legislation. Stronger and more proactive anti-discrimination legislation specifically in the hiring process and in workplace settings is also needed.

At the same time, stronger enforcement of employment standards and occupational health and safety practices is required in sectors/occupations that tend to have high proportions of immigrant women (e.g. caregiving, health care, education, food services and janitorial services). There is also an urgent need to make information and training on workers' rights more accessible so that immigrant workers can take action against unsafe work and workplace exploitation. This information should address wide ranging hazards that reflect the issues of concern of diverse populations. Furthermore, health-care professionals need to pay closer attention to and proactively address health risks facing immigrant women workers and their families who are struggling with under/unemployment. Finally, findings from our study underscore the need to introduce a universal childcare programme in Canada. Recently, there has been a resurgence of interest at the federal and provincial levels for such a programme. Proponents have highlighted the economic and social benefits of this proposal, ranging from reduction of child poverty to more active labour market participation, especially from working women. Universal childcare would have tremendous positive outcomes for immigrant women not only in terms of securing and maintaining good quality employment but also in promoting health.

## Notes

1. In line with the Canadian Race Relations Foundation, we use the term 'racialization'. This term recognizes the dynamic and complex process by which racial categories are socially produced by dominant groups in ways that entrench social inequalities (Galabuzi 2001).
2. Recent immigrants are defined as those who arrived in Canada 1–5 years before the 2006 census reference year. Established immigrants are those who arrived 11–15 years before the 2006 census reference year.

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## Key messages

- (1) Under/unemployment negatively impacts the physical and mental health of workers and their families. It does so directly, for example through social isolation and frustration, and indirectly through representation in poor quality jobs.
- (2) Under/unemployment additionally leads to the intensification of job search strategies and of the household and caregiving workload, activities which also carry health risks.
- (3) These labour market experiences and their associated health burdens disproportionately and differentially impact racialized immigrant women because of the intersection of multiple social disadvantages.

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