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Place, health and home: Gender and migration in the constitution of healthy space

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Abstract

This paper contributes to recent literature that considers the role of everyday activity in constructing 'healthy space', specifically exploring the tension between agency and structural processes in explanation. The focus is a comparison of two groups of migrant women in British Columbia, Canada: South Asian Sikhs from Punjab, India, and Afghan-Muslim refugees. It explores the routine practices whereby they work to create 'healthy space' as they orchestrate their families' health. Through food preparation and consumption practices, traditional healing and religious observance, the women delineate the physical, social and symbolic dimensions of healthy space. The women's narratives demonstrate the productive capacity of everyday routines in forging healthy space within the particularities of migrant settlement. Crown Copyright © 2006 Published by Elsevier Ltd. All rights reserved.

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Introduction

This paper considers the health practices of immigrant and refugee women living in the Lower Mainland of Vancouver, British Columbia, Canada. Specifically it explores how the women's everyday health-promoting and healing activities are implicated in the production of 'healthy space' in a large culturally diverse city.¹ The paper intends to contribute to literature in health geography that is

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¹Vancouver is one of the three main destinations for immigrants to Canada, together with Montreal and Toronto. South Asians comprise the second largest 'visible minority' group

framed by recent work that seeks to investigate the role of everyday activity in producing meanings and experiences of space as 'healthy' or its converse (Gesler, 2005; Smyth, 2005). Such works show differentials in the experience of places as healthy or unhealthy and connect with the larger problematic of the interconnections among place, culture, and health (Gesler and Kearns, 2001). The interesting tension between agency and structure is an ongoing theme—although in reworked frameworks following the well-rehearsed dismantling of a 'macro' and 'micro' distinction initially prompted by Giddens' structuration theory (Dyck and

(*footnote continued*)

in Greater Vancouver, with the community growing primarily through the family reunification category. (www.statcan.ca).

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Kearns, 2005). Our focus is on the possibilities for agency as revealed through the practice of health 'in place'.

The comparison of two groups of women, South Asian Sikhs from Punjab, India, and Afghan-Muslim refugees, serves to build an understanding of how the women's respective relationships to place inform and circumscribe their health practices. The women are of different educational and social background, left their home countries under different circumstances and enjoy different levels of financial and personal security in Canada. While the comparison acknowledges the effects of such differences on the specificity of their health practices, there are notable commonalities related to their *particular* political and social positioning in Canada as ethnic minorities entering through the 'humanitarian' family reunification and refugee categories of Canadian immigration policy.² In the paper we draw on insights from health geography and medical anthropology to unravel how such features of their lives inflect the ways they seek viable space for raising healthy families.

We explore the tension between the political economy framing of the materialities of the women's lives and their everyday carving out of room for agency as they attempt to create healthy homes in diaspora space. While their projects of 'health' and 'home' are constrained and shaped by the effects of structural processes in the form of local material and social conditions, these felt effects are reworked by the women in their day-to-day health practices. However, such practices are not best understood as simply local, but as intricately interwoven with material resources and/or cultural knowledge located and constructed within a context of transnational connections and memories of

'home'. The production of healthy space, then—with the domestic sphere as a core site—situates the women as transnational subjects with a complex relationship to place.

The paper begins with a brief discussion of literature informing the conceptual approach of the paper. A description of the study methods follows. The major sections of the paper draw on data from in-depth individual and group interviews and focus on three areas of everyday health practice; food purchasing, preparation and consumption; home-based or traditional medicine; and religious observance. We use the contrast between the two groups of women to emphasise the embeddedness of the women's material and ideational projects of 'home' and 'health' in the interlocking of immigrant status, local materialities, and a transnational sense of belonging. We conclude with comment on the contribution of our analysis to theorising the production of 'healthy space'.

Situating migrant women's health practices

Following the lead of Gesler (1992) interest in how healing processes are associated with particular places, geographers have examined the use and experience of places of healing in a variety of settings (Williams, 1999). Particular landscapes are found to be not intrinsically healthy or unhealthy, rather they may be used, experienced and perceived differently by different people (Conradson, 2005; Gesler, 2005; Wakefield and McMullan, 2005). Eschewing an exclusive focus on 'exotic' healing places, and following work on the part played by everyday activity in the cultural production of landscapes as material, symbolic and lived cultural phenomena (Cresswell, 2003), there is heightened interest in the productive capacity of everyday activity in the construction and experience of 'healthy spaces'. A variety of spaces that are conducive to health and well-being are being explored (Smyth, 2005). The gendering of the productive action in constructing healthy space, however, has received little attention, and migrants have been invisible in the 'cartography' of healthy spaces.

Work in the therapeutic landscape tradition of health geography, nevertheless, provides a potentially useful perspective in studying migrant health practices through its recent emphasis on process and diversity. Early recognition of the tension between local action and wider processes in producing spaces

²Both groups of women entered Canada through the 'family reunification' or 'humanitarian' categories of Canada's immigration and refugee policy. These are set against business and skilled worker categories of immigration policy, which channel particular forms of human and financial capital into the Canadian economy. In 1999 economic immigrants (skilled workers, business investors, entrepreneurs and the self-employed) comprised 56% of those entering Canada. Twenty-nine per cent were sponsored family members ('family class' immigrants) and 13% were refugees (Citizenship and Immigration: <http://www.cic.gc.ca>). Feminist scholars comment on the social and economic marginalisation of women entering Canada as family class immigrants or refugees, with the contribution of their reproductive work obscured, as is the low paid work they do in maintaining the financial viability of their households. (Abu-Laban, 1998; Grace et al, 1998).

of well-being, and the acknowledgement that different groups may experience landscapes differently, suggest that the everyday actions of migrants need situating within the imbrications of local and global processes in their lives. Anthropology also has a long engagement with the tricky explication of tensions between 'structural' forces and agency, revitalised through work on gender and diaspora within the context of contemporary globalisation. Diaspora refers to the intricate ties that migrant communities maintain with their homeland and, as Elmhirst (2000: 487) states, "provides a useful way of framing identities" that challenges a static view of "an ahistorical indigenous identity". Diasporas, as cultural and political terrains, are shown to be gendered, with myth, memory, history and travel as media through which home is reconstituted in the country of destination (see Brab, 1996; Yeoh and Willis, 1999). Women are seen to reconstruct and rework hegemonic scripts of identity through everyday practices blurring 'public' and 'private' space (Mankekar, 2002; Yeoh and Willis, 1999) and by constructing transnational identities (Panagakos, 2004). A crucial area that remains unexplored, however, is that of women's work in constituting healthy homes in diaspora, with home understood in the sense of a transnational domain.

The promise of a focus on everyday practices in revealing the workings of human agency is particularly emphasised in feminist work, which insists that it is in local materialities, linked to the wider world through reciprocal processes, that we can see women's cultural and place-making work (Massey 1994; Ong, 1999; Staeheli, 2003). This point needs elaboration in light of an orientation where the global is "macro-political economic and the local is situated, culturally creative and resistant" (Ong, 1999:4). To forestall analytical confinement of the local to the cultural, Ong suggests that we "analyze people's everyday actions as a form of cultural politics embedded in specific power contexts" (Ong, 1999:4). Narrative accounts from marginalised subjects are particularly valuable in such excavation (Lawson, 2000).

Studies in health geography and medical anthropology take up such a focus and methodology, looking at the *particular* location of certain minority groups within the power relations surrounding flows of migrants to western nations. Kerner et al (2001), for example, discuss the impact of 'Temporary Protected Status' on the health and health care behaviour of Salvadoran women in the US, and

Grove and Zwi (2006) note the 'knock-on' effects of the social marginalisation of forced migrants on their health. Dossa (2004) similarly points to the significance of immigration processes in shaping how Iranian women re-construct place in Canada, while Manderson and Alotey (2003) further show the complexity of such processes as a context for health behaviour in the Australian context. Studies such as these echo Ong's work (1995, 1999), which considers the biopolitical construction of Cambodian refugees in California as "a particular kind of American minority" within dominant ideas of "healthy and culturally correct subjects" (1995:1246)," a status that defines them as 'Other'.

It is in this stream of work, which indicates the intertwining of social, economic and political processes at various spatial scales, that we see immigrants and refugees as creative agents in negotiating their 'Otherness' as they seek to construct healthy lives. This work informs both our analysis and our use of qualitative methods in seeking insight into the negotiation of healthy space from marginalised locations in society.

Study methods and participants

The women were recruited through settlement agencies. Individual semi-structured interviews were conducted with 10 South Asian women and 10 Afghan women. Six additional South Asian women and four Afghan women then participated in four sequential group interviews. South Asian and Afghan research assistants conducted the interviews in the women's first language. They were invited to talk about their experiences of immigration and various aspects of living in Canada, including their mothering work, household organisation, paid work and ways of managing health and illness. The group interviews promoted an interactive, story-telling mode of communication and allowed women to discuss the same issues in some depth. The field workers used the same interview guide and pursued similar topics in the group interviews but, following the established principle of qualitative research, the sequencing of questions was not strictly adhered to and women raised topics of particular concern to them (Hammersley and Atkinson, 1995). Close collaboration with the field workers, however, ensured uniformity in topics covered. Close reading of transcripts and comparison across both types of interviews and groups of

women involved discussion among researchers of emerging substantive and theoretical themes.

The South Asian women, all Sikhs from Punjab, India, lived in various low to middle-income city and suburban neighbourhoods of Vancouver and a smaller city of the Greater Vancouver area, where there are concentrations of immigrants from India, principally from Punjab. Most lived in well-maintained single-family dwellings and all but one was married. All but two, one with teenaged children and one a single parent, lived in nuclear or extended households with children of elementary school age. They had been in Canada for between 2 and 20 years, and had low education levels (high school) relative to the Canadian born population. Like their husbands, all except two (one being a grandmother who cared for her grandchildren during the day) worked in low or semi-skilled sectors of the labour market. They held jobs in food processing plants, farming, a flower nursery, and cashier or restaurant work while some were training for similar jobs. None had worked for pay in India.

The Afghan women, all Muslims, had been in Canada for 2–15 years. All had children and four were the female heads of single-parent households, having lost husbands through war. All but two entered Canada as UN Convention refugees via other countries, including India, Pakistan and Iran. They were placed by settlement agencies in a low-income housing area in a culturally diverse inner suburb that is part of the urban sprawl of Vancouver, and most lived in apartment blocks. In contrast to the South Asian women, their educational level ranged from high school to university. Prior to coming to Canada, like their husbands, most had worked in skilled occupations. Their previous jobs including teaching and research laboratory work, while one had been a seamstress. They had experienced de-skilling in Canada, with most holding part-time jobs in service occupations, such as cashier and casual retail work, childcare and house cleaning. One was a store manager in a family business. All, however, described themselves as homemakers.

Negotiating healthy homes from a migrant location

In the following discussion we consider aspects of immigration and settlement experience that frame the ideational and material projects of 'healthy homes' and 'healthy bodies' which underpin the women's construction of healthy space. We focus on

three specific domains of health practice and their spatiality that were prominent in the women's narratives: preparing nutritious meals, managing illness episodes, and prayer. Their accounts bring home that for them keeping healthy is not an atomised activity, but one bound up with their experiences of migration and settlement. We see their health work filling in gaps in biomedical practice, using traditional remedies as a valued system in its own right, and the performance of cultural work in the constitution of 'healthy' identities in the context of diaspora. How health practices were interpreted and enacted indicate the linking of mode of entry into Canada, the subsequent material, social and economic conditions of the women's day-to-day lives, and past cultural practices relating to a remembered 'home'.

Gender and migration

Migrant women's experiences of particular places will vary according to whether gender identities are reaffirmed or challenged through migration (Boyle, 2002). In our study there were marked differences in the circumstances of migration, with the forced migration and refugee status of the Afghan women contrasting with the planned migration of the South Asian women who entered Canada as 'family class' immigrants. However, despite the considerable difference in the women's migration and settlement experience and in the human capital that they embody in terms of educational qualifications and job skills—normative constructions of gender, associating women with the domestic realm, were reinscribed through migration. For the South Asian women, migration patterns in which family reunification has been central, with women entering as dependants, serve to reaffirm their primary responsibility for health and care work. For the Afghan women, identification with the home and children's futures take on particular significance in the context of absence of labour market participation appropriate to their qualifications, ruptured families and lost homes.

Whereas the South Asian women had joined husbands, fiancés or other relatives in a well-established Sikh community, and continued to enjoy connections with India through, for example, the exchange of goods, a flow of visiting between the two countries and ongoing migration from the same region of India, the Afghan women's accounts depicted severance and loss. Ongoing conflicts in Afghanistan had affected them all and none

anticipated return; as one woman commented, “War in our home country has left us with broken families”. The different modes of entry into Canada for the two groups of women spilled over into the material and social conditions underpinning their health practices. The thinly resourced landscape of the Afghan women, relying on social services, newly made acquaintances and poorly paid work or welfare payments, contrasted with the South Asian women’s often rich family life, familiar goods and services, and dense social networks of the Sikh community. The South Asian women talked about it being easy “to make a lot of ‘aunties’”, an affectionate nomenclature for other Sikh women with whom they could engage in social life and enlist support, whereas the Afghan women were more likely to speak of loneliness. Shirin, for example, spoke of her isolation from her extended family, “At times, I just sit and cry for hours”.

There was contrast, too, in the two groups of women’s economic standing and financial security. Although the South Asian women worked in low paid jobs, as often did their husbands, two incomes and a variety of in-kind support—such as help with job finding, house maintenance and with child care and housework—gave them some financial stability, secure housing and a sense of belonging in their neighbourhoods. As one commented, “I didn’t have much of a problem coming over because I was coming into my own family ... I didn’t have a problem finding employment because my brother worked there [a flower nursery] already”. The Afghan women on the other hand, whether as lone parents or married, spoke of their precarious financial situation and considerable uncertainty about their future prospects in Canada. None had been able to translate their past educational and professional skills into the labour market, nor had their husbands, and they were re-evaluating the priorities in their lives. Nargis, for example, whose husband was killed in Afghanistan, came to Canada with her four children after being in Iran for seven years. Financially dependent on the state for three years, and living in overcrowded conditions in a two-bedroom apartment she saw her children as her priority in Canada: “I have a big responsibility on my shoulder. ... [the children] have been homeless for a long time ... They have suffered a lot. They need help”. Similarly, Shirin experienced a reduced material life and financial insecurity. She had reworked her priorities around her children’s needs and their futures, commenting, “mothers have the

responsibility of making sure that kids grow up to be good citizens,” and that children “should be happy and healthy”.

For both sets of women, it is under the conditions of migration that they interpret meanings of healthy homes and healthy bodies, and attempt to translate such meanings into everyday health practices, as we go on to discuss in the rest of the paper. When the women talked about food, dealing with illness, and religious practice, therefore, their different relationship to place framed their experiences and actions. This not only related to home and neighbourhood space in Canada, but also to their countries of origin, which remained an anchor point in their discussions of healthy homes and healthy bodies.

Food, health and cultural negotiation

Both groups of women combined long-standing knowledge about healthy food from their countries of origin with knowledge gained in Canada through a variety of sources, such as doctors, their children’s schools, television and print media. They included both indigenous cuisine and Canadian foods in the repertoire of their household consumption patterns. While there were differences in the specificities of food products used in the home, both groups of women sought to meet the needs of children growing up as Canadian citizens. Like the Bengali-American families in Ray’s (2004) study, the women can be seen to be navigating from home the public institutions signifying modernity and the ‘ethnic’ spaces of community life, holding in tension the cultural knowledge of ‘home’ with that of dominant narratives of Canadian belonging. To be an ‘appropriate citizen’ indicates notions of appropriate food consumption, so that food practices are not neutral but set within relations of power and exclusions of national cultural imaginaries (Gunew, 2002; Probyn, 1998). Furthermore, to be a ‘good citizen’ is to take responsibility for eating healthily; certainly a plethora of public health messages about nutrition and food consumption appearing in a variety of media complicate the relationship between food and health (King and Watson, 2005).

This complex meaning of food showed in the women’s accounts, reaffirming the notion that food signifies and presences social and geographical worlds (Bell and Valentine, 1997). However, while there were commonalities in their provisioning strategies, their different migration histories framed their specific practices and the way in which a

personal politics of food interwove with the notion of the home as healthy space.

With homes in areas of the city and Lower Mainland where Sikhs are clustered, and with the institutional depth of a Sikh community, the South Asian women had ready access to the stores and markets of the locally known 'Little Indias'. As one woman said "you can get everything here" [to create traditional dishes] and, like others, noted the freshness of local produce that they considered central to producing a healthy meal. Cooking and eating Indian food, primarily vegetarian, was common and emphasis was laid on cooking from scratch. Although home preparation of meals was time consuming, and several of the women were in paid employment, it was part of all the women's household routines. The ready availability of inexpensive ingredients and often help with cooking from family members, such as a grandmother or sister-in-law, facilitated the inclusion of well-known recipes and ways of cooking into what the women considered a healthy lifestyle. Nevertheless, ideas about healthy food were not static. Children were purveyors of nutritional information acquired at school, which women heeded; Surjeet, for example, said; "Now when [my son] tells me that his teacher said they should eat certain things, I buy those things." The women spoke of how they tried to avoid 'risky' food that they learned about through schools, the media or through their local social networks; the spicy, fatty, salty, high sugar content food they had been accustomed to in India was sometimes modified.

The Afghan women also emphasised the importance of fresh ingredients and cooked familiar dishes, but finding appropriate ingredients was a more difficult and time-consuming task than for their South Asian counterparts. They found some spices locally but travelled several kilometres across the city to specialist outlets to buy other foodstuffs necessary for indigenous recipes. Like the South Asian women, the Afghan women were conscious of health messages about food ingredients, and had learnt about hidden salt and sugar in canned and packaged foods from the media. They modified traditional recipes so they consumed less salt and fat, as one noted, "the meat that we buy here comes with a lot of fat but this was not the case in Afghanistan", and some talked of screening out oily food or ingredients grown with pesticides. They worked hard to serve balanced meals that included vegetables, rice, meat, fruits and milk. Often living

on a precarious income, they spent extra time shopping for affordable foods, wanting to avoid cheap fast-food for health and cultural reasons. In common they felt Afghan cuisine was important from the point of view of reconstructing a disrupted life and ensuring the children did not lose the "taste" of Afghanistan. As Shirin put it, "our children must not forget what it is to be a Muslim and what it is to be an Afghan."

Nevertheless, while traditional fare was the mainstay of food served in the home, both groups of women recognised that raising children in Canada also meant that Canadian foods needed to be part of the household's foodscape. Some of the South Asian women spoke of accommodating the desire of husbands, too, to include Canadian foods, including meat, in the weekly round of dishes. Fast foods such as pizza, pasta and hamburger, eaten out, were used as a treat for children or to reward their success at school. While the women considered 'outside' food as inferior to home-cooked food, they saw it important that children participated in the food culture of Canada if they were to be successful in Canadian society. Like the South Asian women, the Afghan women wanted to raise children true to their cultural heritage, but also wished them to be part of Canadian society. They responded to children's desires to eat foods representing Canadian popular culture and tastes, usually preparing these at home, modifying ingredients.

Food, then, was not simply a nutritional issue but one of negotiation of cultural belonging. The home was a 'safe' site for the production of healthy food, admitting Canadian tastes as well as adhering to valued cultural food practices. In the case of the Afghan women, there was also evidence of a more direct politics of food. One Afghan woman, for example, spoke of the 'multicultural days' at her children's school (when parents brought in ethnic foods) as a site for such cultural negotiation and claiming validity for an Afghan identity. She used such events as an opportunity for telling politicised stories of life in Afghanistan to teachers and non-Afghan parents, so adding to the variety of narratives of 'belonging' in Canada. Lee and Cardinal (1998: 230) suggest that mothers' transmission of cultural knowledge provides 'other' bases for identity formation for children that have the potential to destabilise the "hegemonic core of Canadian nationalism." Yet, in their food work, the women in our study were working a balance between Canadian 'belonging' (through acceptance

of Canadian popular food) and cuisine that provided a transnational sense of home. Children, too, negotiate their cultural identities as they bring consumer culture, tastes and Canadian public health knowledge to the family table. The home in these ways is constructed as healthy space, fostering healthy physical bodies and ways of appropriate cultural belonging.

Healing knowledge and spaces

The association of food with a migrant identity and a remembered, distant home was particularly sharp in discussions of the use of herb- and spice-based traditional and home remedies in illness management. Here too the significance of social networks in settlement experience is apparent (c.f. Baader, 2005; Hagan, 1998). Literature on immigrant's use of traditional healing methods tends to focus on a debate between an interpretation of their use as cultural conservatism or efficient consumerism (Chabot, 1999). The examples from the women of our study suggest such debate must take account of the larger context of the negotiation of this health work. Difference in use of traditional remedies cannot be simply associated with different educational levels and debate over the value of 'modern' medicine over traditional knowledge. The women's accounts indicate how their experiences of the dislocation of home, together with current experiences of diaspora space, situate their negotiation of competing health care knowledges.

Women from both groups showed a rich knowledge of alternative healing practices, transmitted over generations, but their use was much more common among the South Asian women. South Asian women regarded such *desi* medicines as "part of our culture" and as safer than prescription medicines. They found them cheap, easy to use and many ingredients were readily accessible in local shops and markets. A typical approach was, "we see what the problem is and give the appropriate treatment", considering both home remedies and the biomedical health care system in responding to illness. They favoured a preventative approach to illness.

Desi meds may not have benefit but they don't have a side effect either. ... but you don't give a person with a heart attack *desi* meds and keep them at home. For this type of thing, you need to go to the doctor. ...

Women were able to purchase most ingredients for *desi* medicines locally, and incorporated ingredients with medicinal qualities into daily routines. As one woman described,

We make *sund* once per week and we have ginger and garlic in there with *paneer* [cheese] so the kids will eat it. If we do this once per week, it helps alleviate certain issues like stomach problems.

A variety of traditional healing remedies were taken for granted as an appropriate approach for well known conditions, and social networks were important in the exchange of information and in supporting women in their quest for good health. The following story taken from a group interview indicates valued collective cultural knowledge and the familial links in problem-solving around health problems:

Doctors can't diagnose *thurn* here, but we know what it does; you get an upset stomach, food doesn't digest properly, hands and feet hurt. ... And there is another one called *gurd*—and if you have both *thurn* and *gurd*—well, then doctors here will keep you in the hospital and not get rid of it. But our elders know what it is and how to deal with it. ... My niece comes here from Comox and gets it [*gurd*] taken out because doctors don't know about it, but us Punjabis know about it.

Women commonly share knowledge of remedies with friends and acquaintances, and knowledge of traditional healing approaches is widespread in the community. Women spoke of gaining healing information from a number of sources; for example Haminder commented, "[I hear from] the Punjabi papers or through an elder—like an auntie or uncle. If we tell someone what problem we have—they tell us what *desi* medicine to use. Transnational networks also figured in their accounts, with women speaking of relatives sending medicines from India and family members consulting a traditional healer on visits back to India.

This operationalisation of a collective knowledge through networks spanning Canada and India contrasted with the Afghan women's experience. The political history of Afghanistan figured prominently in women's accounts of managing health issues. They talked of Afghanistan as an unstable, shifting landscape of care. Its virtues as a source of herbal remedies and modern medicine were now in question, but it continued to be a source of

knowledge, as well as yardstick in assessing quality of health care in Canada. In nostalgic accounts the women spoke of the violence to a landscape of healing. One spoke of the remedies they used in Afghanistan now being beyond their reach: “instead of herbs, the country is filled with landmines”. Others noted the deterioration of the health care system through regime changes and foreign intervention:

Before the Mujahideen and the Taliban we had a great medical system. We had very nice hospitals and very smart and well-educated doctors. ... These hospitals were very modern ... Today we have nothing, but back then we had everything. We were a modern country.

The women stressed this situation, aware that the West has looked upon Afghanistan as ‘inferior’; in Said (1978) terms through the discourse of Orientalism that has contrasted a uncivilised and barbaric ‘They’ with the civilised and progressive ‘We.’ Women went out of their way to explain that in peaceful times (pre-Soviet Union invasion) Afghanistan had a viable system of health care that included both biomedicine and alternative healing, and people judged which would work best for them. Women talked of foreign occupation undermining this system with the result that healing and tending of the sick had become a home affair taken care of by women. They spoke of using traditional remedies for “minor things, like chest pain, ear aches and cold.” They had combined biomedical and traditional remedies, one woman giving the example of her father-in-law who had high blood pressure. The woman described a powdered substance made from cherry seeds that “we would put in a bottle for him to take” and spoke of giving him the water from boiled *sinjeut* and *lekai* leaves to keep his blood pressure normal. Few, however, used home remedies in Canada. Some women consider their usage as part of a practice embedded in female-centred networks, which are now lost to them. They also noted the lack of interest in home remedies in the younger generation. As one woman said, “The new generation looks for modern day new things ... they want to look to the future and not the past”.

Ray’s (2004) suggestion that food practices of migrant cuisine slowly assert a reorientation of hegemonic conceptions of place can be paralleled with home healing practices. In our study, use of traditional healing practices by the South Asian women served to claim space for alternative

conceptions and modes of healing that contest dominant biomedical constructions. As in food production, remedies made and administered at home are constructed by the women as a component of home as healthy space. Such healthy space, however, is not confined to the local but incorporates material and symbolic aspects of a distant home of origin, both in terms of living cultural knowledge and material health-giving substances. The Afghan women have lost connection with such home-based healing expertise, instead seeking care primarily through the Canadian health system.

Prayer, health and place

Prayer is our last example of women’s constitutive activities of healthy space. As a component of healthy space, we look at how and where the women use prayer in their daily lives. Religious observance has received scarce attention in literature on migrant health. For the women, it was part of a bundle of health-promoting activity, as well as an expression of religious observance, it provided both groups of women with moments of repose and a way of coping with worries as they took on the multiple responsibilities of work in the domestic sphere, often in conjunction with participation in the labour market.

As with food provisioning and illness management, the practice of prayer spans home, neighbourhood and institutional space. While some South Asian women attended one of the established *Gurdwara* regularly, and Afghan women attended Friday prayers at a makeshift mosque in a school in their neighbourhood, the home remained the core site for prayer. Prayer was talked of as everyday practice, usually seamlessly integrated into the temporality and spatiality of everyday chores. While prayers might be used throughout the day, all noted prayer at the start of the day as a firm routine. A South Asian woman’s description of the beginning of her daily routine as “I put on tea and start prayers” was typical. An Afghan woman similarly included prayer along with her mothering practices as she described her busy daily schedule; “I get up early in the morning and I say my prayers. I make sure all my sons wash up and wear proper clothes for school. I also make breakfast for them”. Prayers were said at other times of the day, too, either at home or as women went about their daily chores.

For the South Asian women prayer is a taken-for-granted practice, part of belonging to the Sikh community. There is a known repertoire of prayers

of different lengths, with different requirements as to when they should be said. However, the women indicated flexibility in how and when prayer could be used, as illustrated in one exchange:

Woman 1: In the morning I do *Sukhmami Sahib* [a prayer that does not have a recommended time] and the five bharnes and in the evening I do *Rheas Sahib*

Interviewer: *Sukhmami Sahib* is a long one, how long does it take you?

Woman 1: It just seems really long in the beginning but it only takes 35 minutes

Woman 2: If you can't do it in the morning—you can do it in the afternoon or at night or before you go to sleep

The Afghan-Muslim women also spoke of the flexibility in how they practised prayer in Canada and the modifications they made, including the use of public space. One noted, "The important thing is that we pray. This does not mean that we can always pray five times a day or that we always have the time to put on [special prayer outfit]". Women used strategic moments to say a few minutes of prayer in a sitting position, wherever they might be, with their head covered and facing Mecca when possible. An exchange with Nargis, who had asked for a few minutes to pray during the interview illustrates this slotting of prayer into the spaces of her daily routines.

Interviewer: Do you often pray in public?

Nargis: Whenever I get the opportunity. Lunch-time is a good time, but any time is fine.

Interviewer: Do other people [non Muslims] make any comments?

Nargis: Sometimes they ask me questions. Other times they say nothing. They carry on with whatever they are doing.

Prayer was a central feature in their day-to-day lives and they spoke of its particular significance for them as they struggled with their current situations. Shirin explained that it was prayer along with faith in Allah that helped her and other Afghan women to cope with the loss of family members in Afghanistan, as well as coping with their new life in Canada. Some women read *Quran-e Sharif* during times of the day when they felt depressed or sad. Prayer was also core to their identity as Afghan-Muslims and they encouraged children and grandchildren to pray as part of maintaining traditions and culture.

While the Sikh community's religious faith is visible on the landscape through the substantial buildings of *Gurdwara* echoing the style of those in India, the Afghan women do not have a direct counterpart. Instead, the visibility of the temporal and spatial dimensions of their faith in 'everyday' public spaces is created through the women's embodied practices. The integration of home, prayer, health and healing suggests, however, that the everyday rituals of prayer comprise a project beyond that of religious observance and everyday coping. Abu-Lughod (1998:3) observes that, "in the post modern world women [their bodies] have become potent symbols of identity and visions of society and the nation," a script that is not denuded of agency. It is through the temporality and spatiality of prayer, embodied in women's practices, that we see women re-inscribing the landscape—extending the healing practices of a 'healthy home' into public space. As they offer prayers in times of crisis, sadness or sickness in homes and neighbourhood space, they further build the home and neighbourhood as healthy space—in material, social and symbolic dimensions.

Conclusions

This paper set out to consider women's agency in producing 'healthy space' in a major immigrant destination city in Canada. In our analysis we have focused on the embeddedness of their health practices in place, bringing to bear a conception of place that dismisses a notion of boundedness. Rather, we attempt to examine the intertwining of the local social and material conditions that frame women's health practices with ongoing transnational attachments and processes of settlement experience shaped by migration patterns and policy. Healthy space is not simply locally constituted but involves relationships and materials stretched over space (c.f. Massey, 1994). Despite the differences in their dislocation and settlement experiences, the narrative accounts of the women express a collective experience of positioning in Canadian society as 'Other'. In the course of their day-to-day practices—obtaining and preparing nutritious food, dealing with illness, and prayer—the women actively seek to create their homes as healthy space within the ambiguities of a migrant identity discursively constructed as marginal to national economic goals. Although differences in forced and planned migration are substantial, in common, also,

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the home country remained an anchor point in the women's interpretation and practice of health (see also Sherrell and Hyndman, 2004).

It is within the various constitutive spaces of 'home', the material, social and symbolic qualities of which span their adopted country and home of origin, that women interpret health and its management. To be healthy involves not only the physical body, but also the ability to participate in Canadian society as an 'appropriate' cultural body. For both groups, access to social and material resources, including housing, work and social networks, frames the specificity of their health practices. For the women from Afghanistan, the difficulties of rebuilding a life are formidable. Their reflections on personal losses are interwoven with the violence subjected on their home country, a violence that spills over to long-held health and healing knowledge and religious faith. Women struggle to make space for these in Canada. The South Asian women enter Canada with 'living' connections with India, through marriages, the exchange of goods, and ongoing migration flows. Yet both groups of women negotiate fields of knowledge and health practices in ways that provide children opportunities to be 'flexible citizens' (c.f. Ong, 1999), who will be connected to a remembered, symbolic homeland as well as citizens of Canada.

We have emphasised the home as the primary site from which women orchestrate and construct their health practices, although these also spill over into neighbourhood space. Taking place in the nooks and crannies of everyday life, their endeavours are not easily discernible. Yet, as noted in feminist work, it is within such hidden spaces that women contribute to place-making, although, as Schepers-Hughes (1992) warns us, the conditions under which women forge their lives can be severely constraining. In conceptualising the women's health practices as constitutive of healthy space within the multicultural landscape of this major city, we suggest their actions, while constrained, indicate the productive capacity of reproductive work. As the women seek to construct healthy lives, we see their agency both located within and constitutive of a complex spatiality of home space and belonging.

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