

**Complicating ‘the right to health care’: Narratives of deservingness among im/migrants in
Sault Ste. Marie, Ontario**

By

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ABSTRACT

COMPLICATING ‘THE RIGHT TO HEALTH CARE’: NARRATIVES OF DESERVINGNESS AMONG IM/MIGRANTS IN SAULT STE. MARIE, ONTARIO.

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In the age of globalization and massive mobility, local and dynamic understandings of im/migration, health, health policy and health care are increasingly important. In recent literature, Sarah Willen and colleagues (2012) introduce the concept of *health-related deservingness*, bringing to the fore local, everyday “reckonings” of who deserves what and why, as opposed to the well-studied entitlement and access dimensions of health and health care. Inspired by this work and by my own experience as an im/migrant in Canada, this study explores the health-related deservingness “reckonings” of im/migrants in the Algoma region of Ontario, particularly Sault Ste. Marie. Through my analysis of various in-depth interviews and a focus group, I propose that experiences (as opposed to conceptions) of deservingness can be at least as important a determinant of im/migrants’ overall health and well-being as formal entitlement and access. Furthermore, because experiences of deservingness are individual/localized, implicit and dynamic, they are more vulnerable to contextual influences and also more ‘negotiable’. This ‘malleability’ of deservingness presents opportunities to re-think im/migrants’ agency, as well as the moral obligations and responsibilities of im/migrants and non-im/migrants alike.

DEDICATION

To my best friend, John Floyd Vincent (February 11, 1988-September 26, 2015), model of compassion for self, others and Mother Nature, and my greatest inspiration in this and many other journeys.

“For every thing that lives is Holy” – William Blake

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INTRODUCTION

This study explores how im/migrants in the Algoma region of Ontario, particularly Sault Ste. Marie, understand and negotiate their deservingness of health and health care. In recent literature, Willen (2012a) refers to deservingness as “the flip side of rights” (813). Rights, she suggests, can be understood as the “juridical discourse that presumes universality and equality before the law”, while deservingness captures the subjective and relational nature of individual moral assessments of who deserves what and why (814). Conceptions of deservingness shape and are shaped by historical, political, economic, and cultural contexts, as well as by individual values and commitments (Willen 2012a, Sargent 2012, Larchanché 2012). They influence discourse and practice in policy-making, institutions, the media and the lives of citizens and non-citizens (Willen 2012a, 814).

Most of what we currently know about deservingness stems from literature on deservingness of welfare. Recent research, however, points to the growing importance of exploring how deservingness is “reckoned” in the health domain (Willen 2012a, 814). In particular, social scientists of health point out that negative conceptions of deservingness not only have direct epidemiological consequences, but can also produce subtle forms of structural vulnerability among im/migrant populations (Quesada 2012, 895). That is, exclusionary arguments of un-deservingness can combine with other forms of social exclusion and barriers to good health and well-being (e.g. racial/ethnic background, socioeconomic status, mental health, etc.) to produce and/or exacerbate precarious living and health conditions (Quesada 2012, 895). This has been shown to be particularly relevant to ‘illegal’ or ‘unauthorized’ im/migrants, whose health-related deservingness is most contested (Willen 2012b, 805). But legal im/migrants and other marginalized populations also face health disparities and barriers to high-quality care that can be attributed to conceptions of deservingness and related exclusionary practices (Sargent 2012, 857). Scholars call on anthropologists to engage with this issue in academia, in policy and in practice, using critical approaches to create a space for vulnerable populations to highlight their experiences of health

and well-being (Sargent 2012, 857). Notably, the perspectives of im/migrants (as opposed to stakeholders, activists, or care providers) in this respect remain greatly under-investigated.

Consistent with current literature, this study takes a critical moral anthropological approach to exploring deservingness as a dimension of ‘the right to health care’. I focus on three key sub-questions: how do im/migrants in Sault Ste. Marie understand health-related deservingness in everyday life? How do understandings of deservingness impact their health and well-being? And, how do they negotiate deservingness? To respond to these questions, I spent six weeks between July and September of 2014 in Sault Ste. Marie. There, I connected with a local im/migration and settlement program called *New to the Sault*, which is considered a “gateway” into the community for newcomers to the Sault Ste. Marie area. With *New to the Sault*’s guidance and assistance, I conducted 10 in-depth interviews, a single focus group and 40+ hours of participant observation. Participants were diverse including individuals from Mexico, India, Japan, Indonesia, Germany, Spain, Pakistan and Argentina, and represented a wide demographic and a variety of occupations. I also attended some of *New to the Sault*’s public activities, including lunchtime get-togethers, weekly educational workshops, and cooking classes. My interview questions and observations focused on im/migrants’ conceptions, expectations, and feelings around health and well-being, health care, self-perception, self-worth and deservingness. I also inquired about what I understood to be some of the potential implications of these factors, including practical and embodied impact on health and well-being.

From a theoretical standpoint, this study aims to provide insight into subtle forms of discrimination, marginalization and social injustice occurring in Canada. This is pursued by exploring deservingness through a health care lens, and questioning patterns of deservingness reasoning and associated exclusionary practices therein. Most importantly, this investigation seeks to contribute immigrants’ (as opposed to health care professionals’) perspectives, which is something that is currently missing from the literature on the subject.

From an ethnographic perspective, this study aims to highlight the lived experience of health-related deservingness of im/migrants in Sault Ste. Marie. In doing so, it provides a space for those affected by subtle barriers to health care to voice their experiences. As these voices begin to reach the public sphere, they will have the potential to impact public policy development. Documenting these (often unheard) perspectives may help add dynamism to relevant public policy by improving health care access and im/migrants' sense of moral worth, and thereby, their overall health and well-being. These implications will be of interest across multiple fields including medical anthropology and sociology, public health, bioethics/public health ethics, health policy and clinical education, and to various stakeholders (e.g. within the Ministry of Citizenship and Immigration Canada [CIC], the Ontario Council of Agencies Serving Immigrants [OCASI], local immigration partnerships [LIPs], local immigration and settlement services, public health officials, etc.), im/migrant and health activists and im/migrant populations.

The public impact of this research will be significant for community development in the Algoma region, and particularly in Sault Ste. Marie. With an aging population, high rates of emigration and limited economic activity, communities in that region have expressed a need for increased im/migration (of Canadians and non-Canadians alike), economic development and labour force diversification (Sault Ste. Marie Local Immigration Partnership 2014). In order to continue growing, these communities will need to ensure that im/migrants feel welcome, supported and comfortable there. Developing im/migration and settlement services such as *New to the Sault*, and knowledge, understanding and public awareness of im/migrants' experiences in the area will be crucial to making the Algoma region an inviting new home for newcomers. This study has great potential to contribute to this knowledge base.

My findings show that alongside formal entitlement and practical access, which are typically anchored in policy and thus presumed to have universal relevance (Willen 2012b), subjective assessments of deservingness also constitute a key dimension of 'the right to health care'. I propose, however, that deservingness, and the relationship among these three dimensions, are more complex than the literature has demonstrated thus far. Most importantly, I found a distinction between conceptions and experiences

of deservingness. Participants' conceptions of deservingness seemed to be a product of conscious reasoning; they were generally tied to formal entitlement and thus applied to people in general. Experiences of deservingness, on the other hand, seemed to be more emotional and less conscious, linked instead to individual self-perceptions and assessments of self-worth. Regardless of entitlement and access, experiences of deservingness affected how people utilized health care, and ultimately, were a determinant of health and well-being. Individual/localized, implicit and dynamic, experiences of deservingness were more vulnerable to historical, socio-cultural, political and individual or local influences, and also more 'negotiable'. This 'malleability' of deservingness presents opportunities to re-think im/migrants' agency, as well as the moral obligations and responsibilities of im/migrants and non-im/migrants. And, by extension, recognizing deservingness as a dimension of 'the right to health care' can help to broaden our ideas of state, citizenship and inclusion/exclusion.

CHAPTER 1: Literature Review & Theoretical Framework

Exploring the nexus of im/migration, global health and morality

The connections among population flows, globalization and human health are infinitely complex. So too are the ways in which these connections have been, and can be, studied. This chapter aims to outline emerging trends in this literature, and to situate this study within them. It begins with an overview of some of the current, overarching debates and trends in the study of im/migration and global health. There seems to be an increasing attention to the politics around im/migrant health and health care as yet another level of complexity (beyond social determinants of health) which impacts individual health vulnerabilities and access to care. In response, scholars are calling for further multi-level (local, state and global) and multi-dimensional approaches to understanding im/migrants' health and health care. Exploring local and dynamic "reckonings" of im/migrants' health-related deservingness (Willen 2012b) is one such approach. Recent work suggests that individual local "reckonings" of undeservingness can have negative subjective, practical and/or embodied consequences that are not necessarily reflected in or accounted for in formal juridical or ethical commitments to health care. Moreover, such "reckonings" can have larger than local roots and impact, since they are often linked to a broader historical, political, economic, socio-cultural and global context. To help address existing research gaps, further work in this area should be critical, ethnographic, focusing on 'irregular' as well as 'regular' im/migration contexts and perspectives, and/or located in emerging im/migration landscapes (for instance, in Canada and in the Global South).

Contemporary trends in the study of im/migration and global health

As a starting point, it is important to note that there is considerable debate among social scientists of migration and health, about the vocabulary that should or should not be used to refer to mobile populations (Castañeda 2010, 7). Across migration research, the term *migrant* has been used to refer to

individuals or groups who have at one point in time re-located to a new place, whether within or between state borders. Some researchers now prefer the terms *migrant* or *im/migrant* as opposed to *immigrant* because they are more comprehensive – they include both the process of leaving a former place (emigration) and that of arriving in a new place (immigration), as well as the possibility and unpredictability of periodic (circular) movement or permanent return to the location of origin (Castañeda 2010, 7 and Willen 2012b, 806). But in North American contexts, the term *migrant* has come to be associated with seasonal re-location (as in the case of migrant farm workers), and less so with permanent or long-term settlement (Castañeda 2010, 8). Even more controversial is the terminology around ‘irregular’ re-location, including terms like *illegal*, *undocumented*, *extralegal*, *unauthorized*, and *clandestine* (Castañeda 2010, 8 and Willen 2012b, 806). Some argue that these terms invoke, and therefore reinforce hegemonic juridical constructions, while others argue that such invocations are necessary in order for de-construction to occur (Castañeda 2010, 8 and Willen 2012b, 806). Finally, as boundaries between voluntary and forced re-location become increasingly blurred as a result of the complex impact of war, natural disasters and persecution, so too does the category *refugee*. Although these debates may seem trivial, they are significant because terminology helps to create categories of entitlement and exclusion that “often remain unproblematized in studies that conflate such nuances of meaning” (Castañeda 2010, 9). To reflect this complex and (as of yet) unresolved debate, I have generally used the more inclusive terms *im/migrant* and *im/migration* throughout my study. This chapter, however, reflects the myriad of terminology found across the literature.

Beyond terminology, much of the contemporary scholarship on migration and health focuses on transnational migration from resource-poor sending locations to wealthier, industrialized ones, primarily in the United States and Western Europe, and on the “contested incorporation” of migrants in these host locations (Sargent and Larchanché 2011, 346). Smaller but growing bodies of research are focusing on internal population movements in developing countries resulting from economic precarity and/or environmental degradation, and on ‘unauthorized migrants’, who have been traditionally excluded from

health disparities research because they are generally considered to exist outside of formal systems and conceptions of rights, citizenship and belonging (Sargent and Larchanché 2011, 346, Castañeda 2010, 19 and Willen 2012b, 805-6). Anthropological research in particular has contributed extensively to the study of concepts of “culture” in relation to health care policy and provision, and to the definition of disease categories (Sargent and Larchanché 2011, 350). The concept of “cultural competency”, for example, gained popularity around the early 2000s in Western medical and public health practice, as a means of addressing the unique needs of migrant populations (Castañeda 2010, 13 and Sargent and Larchanché 2011, 350). Anthropologists have critiqued this approach for oversimplifying “culture” and conflating it with race and ethnicity (Hirsch 2003 and Kleinman and Benson 2006), pathologizing migrant cultures while overlooking biomedical culture (Taylor 2003) and downplaying the impact of socioeconomic factors on health and illness (Farmer 1999 and Hirsch 2003). In a related area of research, scholars have studied medical pluralism, or the blending of traditional and biomedical concepts of health and illness and health care practices (Castañeda 2010, 15). In general, this research has found that medical pluralism is common for migrant as for other patient populations, and that this blending does not necessarily interfere with medical care (Castañeda 2010, 15 and Sargent and Larchanché 2011, 354). In fact, in some cases it can help to make up for the lack of familiar and affordable health care options that migrant populations might face (see for example, Pickwell 1999 and Viladrich 2006).

Consistent with a broader critical and political turn in anthropology in the 21st century, much of the emergent literature in the anthropology of migration and health now points to underlying political, economic, and social structures that produce particular patterns of health and disease, and cautions against reliance on cultural difference to understand these underlying factors (Castañeda 2010, 20 and Sargent and Larchanché 2011, 355). This work is often influenced by political economy and governmentality frameworks as central to understanding the politics of migration, health and health care (Sargent and Larchanché 2011, 347). In the steps of Scheper-Hughes (1992), Kleinman (1997) and Farmer (1999), some scholars are taking “social suffering” and “structural violence” perspectives, and focusing on the

social, political, economic and institutional “determinants” of migrants’ health. They underscore the importance of the economic and political, including lack of health insurance (especially in countries without universal health care systems) and socioeconomic status (see for example, Chavez 2003 and Okie 2007). Other prominent scholars are calling attention to how the social construction of particular migrant groups by dominant groups might be used to ‘manage’ foreign populations, while avoiding responsibility for addressing socioeconomic inequalities and resulting health disparities. Social constructions of migrants’ reproductive health and reproductive decisions are particularly important in this respect because, to the extent that they are linked to national identities and citizenship, they can help to delineate boundaries of political and social inclusion and justify uneven power relations¹ (Ginsburg and Rapp 1995, Castañeda 2010, 20 and Sargent and Larchanché 2011, 349). In countries that follow *jus soli*² citizenship models, like the US, France and Costa Rica, migrant women are often constructed in popular narratives as highly-fertile individuals that take advantage of, and burden health and social services (Chavez 2004 and 2008, Sargent 2006 and Goldade 2009). Similarly, in countries that follow descent-based citizenship models, migrants are perceived to threaten the existing socio-cultural fabric with cultural displacement (Willen 2005, Castañeda 2008 and Sargent and Larchanché 2011, 346). These constructions, in turn, fuel anti-immigrant sentiments across public and policy arenas. More broadly, migrants are also often conceptualized in the public and policy discourses of receiving societies as ‘at risk’ populations for serious communicable diseases, such as tuberculosis and HIV/AIDS (see for example, Farmer 2003 and Chavez 2008). This helps to justify restrictive immigration policies while ignoring entrenched structural conditions underlying disease transmission (Farmer 2003, Abel 2007 and Sargent and Larchanché 2011, 352). In addition, particular migrant populations may be conceptualized differently from others,

¹This refers to the widely used framework of “stratified reproduction,” defined as “the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered” (Ginsburg and Rapp 1995, 3).

²In a *jus soli* citizenship model, anyone born within state borders is eligible for nationality or citizenship (Castañeda 2010, 16).

depending on their perceived economic and/or political ‘value’ to receiving societies (see for example, Horton 2004, Briggs 2005 and Larchanché 2010). In the US, for instance, public health and medical professionals tend to consider Cuban immigrants more likely to become responsible and self-disciplined citizens than Mexican immigrants, who are more commonly associated with illegality (Horton 2004). Cubans are thus often thought to be more ‘deserving’ of citizenship benefits and encouraged to pursue them. Larchanché (2010) finds a similar hierarchy of human value in France, where immigration rhetoric has shifted from the ‘infectious bodies’ of African workers to ‘socially deviant’ African families. This shift corresponds with a marked increase in family reunification applications as opposed to labour immigration (Sargent and Larchanché 2011, 347). Finally, in the Canadian context, there has also been a temporal and value-based shift in social constructions of migrants across Canada’s immigration history. Most recently, public and policy discourses regarding “fraudulent” and “bogus” refugees have helped to justify an increasingly restrictive asylum system (partly manifested as a decrease in health care benefits for most asylum-seekers and refugees), and contributed to a climate of fear with regards to foreign populations more generally (Molnar-Diop 2014). This is in keeping with increasing population flows, border securitization and migrant criminalization worldwide. It is important to note that scholars have observed many such constructions and conceptions to be unfounded.

On the other hand, reproductive decisions, illness, and the body more generally, can serve a perhaps more positive but perhaps problematic purpose for migrants themselves. Using the body as a political tool presents opportunities for migrants to negotiate alternative forms of social (if not political) legitimacy and access to state resources. In Costa Rica³, Nicaraguan migrant mothers can access state-funded vitamins, medications for existing conditions or for nausea and vomiting, ultrasounds and regular checkups during pregnancy, and tubal ligations as a form of contraception following delivery (Goldade

³Costa Rica’s social security system, including a universal health care system, is one of the most developed in Central America, and a source of national pride (Goldade 2012).

2011, 560-563). While having Costa Rican children (as a result of a *jus soli* citizenship model) does not make it easier for the mothers to obtain legal Costa Rican citizenship, it makes them “virtually invisible” to immigration authorities, and therefore less vulnerable to criminalization or deportation (Goldade 2011, 557-558). Across Europe, migrants are also increasingly making reproductive decisions with an eye to how these will affect their access to work, social security and rights to settle (Bledsoe 2004, 88-89 and Sargent 2005). But using the body to incite sympathy and attention is rather a ‘last resort’ in an effort to legitimize their social and political existence (Fassin 2011, 221). This is clearly illustrated in the well-researched French immigration context, wherein immigrants can be granted residency documents based on health issues. Following a marked decrease in political asylum in the 80s and 90s⁴, the French immigration system established a new immigration category. People with serious illnesses who could prove (as confirmed by medical experts) that they could not receive appropriate treatment in their home countries, could obtain a legal temporary residency permit, endorsed for humanitarian reasons (Fassin 2001, 4 and Ticktin 2011, 89). Applications for residency permits under this “illness clause” increased sevenfold over the 1990s, and three quarters of these were favorably assessed (Fassin 2001, 4 and Ticktin 2011). More than 10 percent of residency permits are now granted on medical grounds. Among other entitlements, these permits include the right to receive free medical care for the health condition in question⁵ (Fassin 2001, 4 and Ticktin 2011). The impact of the illness clause extends across local, state and global levels. For immigrants, it affects the “consciousness of their identity”, legitimizing illness to the point where they must seek to be ill, and must perceive themselves as victims in order to justify their own existence in France (Fassin 2001, 4 and 2011, 221 and Ticktin 2011, 13). At the state and global levels, it helps to justify an increasingly restrictive asylum system, while maintaining the ‘humanitarian’ quality that is so critical to French national identity and self-perception (Fassin 2001, 3-4). In a related

⁴Particularly with respect to those of North African origins and/or Islamic religion.

⁵Notably, however, this type of immigration status is still quite precarious because it must be renewed every three to twelve months, and may not allow the individual to work in the country (Fassin 2001, 4).

example, refugee advocates in Canada (including many health care professionals) repeatedly evoked asylum-seekers and refugees' health-related vulnerabilities to contest cuts to government-funded health care for this population in recent years⁶ (Frecha 2015). Many of their public appeals against the cuts were on behalf of people who are either generally considered to have the most serious health conditions (cancer, HIV/AIDS, diabetes) or to be the most defenceless (pregnant women, children, victims of abuse) (Frecha 2015, 11). These appeals were significant and perhaps necessary: they garnered attention and made some gains for refugees and asylum-seekers. At the same time, it can be suggested that the appeals tended to combine an element of vulnerability vis-à-vis refugees and asylum-seekers, with an element of benevolence with respect to 'Canadians' (Frecha 2015, 11). In doing, so they seemed to draw more attention to Canada's humanitarian persona than to its history of marginalization and discrimination against foreigners, and to structural injustices that persist as a result of this history. Narratives that "frame" undocumented immigrants as "effortful," "self-sufficient" and/or "victims" have also been employed across social scientific and public health scholarship in the US to oppose exclusionary public and political discourse (Viladrich 2012). Viladrich (2012) suggests that such narratives can privilege select groups of immigrants "at the expense of framing health care as a universal human right" (827). While strategic framing can be successful in drawing public support, calling for selective or progressive inclusion contradicts the principle of health as a universal human right (Viladrich 2012, 827). Still, framings that challenge "the overarching vilification of unauthorized immigrants" can be considered "a step in the right direction" (Viladrich 2012, 827). Ong (2006) adds the example of migrants in South Asia, who are increasingly able to obtain immigration permits, not only on 'humanitarian' reasons, but

⁶The Interim Federal Health Plan (IFHP) is a temporary health insurance program available to refugees, protected persons, and refugee-claimants in Canada who are not otherwise covered by a provincial, territorial, or private health insurance plan (Citizenship and Immigration Canada [CIC] 2016a). In 2012, the Canadian Federal Government introduced a new (more restrictive) refugee determination system aimed at improving efficiency and fairness in the refugee determination process (Barnes, 2012). This reform reduced IFHP coverage for all refugee-claimants and some subgroups became ineligible for any care. Prior to this, IFHP provided health care coverage similar to that provided by provincial and territorial governments for Canadians receiving social assistance.

also based on the dependency of South Asian economies on them as healthy, able-bodied workers (e.g. maids, factory workers and sex workers). In some contexts, unauthorized migrants are even beginning to use hunger strikes or self-mutilations to protest against threats of deportation and to “legitimize their social existence” (Fassin 2011, 221).

Many of these examples across the literature seem to constitute what Fassin (2009) calls “the moral economies of contemporary societies” (48); the “production, circulation, and appropriation of norms and values, sensibilities and emotions” (Fassin 2012a, 10). When states invoke moral sentiments as a form of governing, the political and contentious becomes blurred with the supposedly apolitical and ‘acceptable’, and so political action may be wielded as humanitarian or compassionate (Fassin 2009, 50 and Fassin 2011, 221). Moreover, when political action concerns immigration and health, ultimately, it is about how states/societies understand and value “life as such,” and the worth of individual lives, more concretely (Fassin 2009, 49). In the simplest terms, it concerns the question of which individuals are ‘worthy’ of a chance at a better life. Such are the types of questions that Fassin suggests are being increasingly deployed as humanitarian or compassionate. Emerging moral economies and the “politics of life” are not only a concern in migration contexts but everywhere, where social, political and/or economic inequality exists (Fassin 2009, 9 and Nguyen and Peschard 2003).

Overall, two trends are particularly salient within this literature: 1) scholars are paying increasing attention to politics of entitlement and exclusion as a key determinant of health vulnerabilities and access to health care, and 2) there is a need for multi-level (local, state and global) and multi-dimensional approaches to understanding how migration, health and the politics of exclusion and entitlement are produced (Nguyen and Peschard 2003, 467, Sargent and Larchanché 2011, 345 and Sargent 2012, 856). In particular, investigating the “making of migrants’ subjectivities” and the contemporary “moralization of politics” around the human body may provide new insight into the links among social inclusion/exclusion, inequality and the production and management of migrants’ health worldwide

(Giordano 2008, Sargent and Larchanché 2011, 345 and Fassin 2012a, 10).

Where does deservingness fit in?

At the nexus of migration, health and morality, social scientists are calling attention to local and dynamic “reckonings” of im/migration and health policy, health and health care (Sargent and Larchanché 2011, 347 and Willen, Mulligan and Castañeda 2011, 347). This implies an interest in various dimensions of ‘the right to health care,’ including entitlement, access and moral assessments of deservingness (Willen 2012b, 805-806). Willen (2012b) explains that, while we have “well-developed analytic toolkits” for investigating formal assertions of entitlement and practical questions of access, “the subtler moral positions that undergird them” remain under-investigated (805). In a compelling collection of literature on immigration and health, Willen and colleagues call on social scientists to help address the complex relationship between health rights and what she calls “health-related deservingness” – the ‘everyday’ interpretations and enactments of formal juridical and/or ethical commitments to health care (Willen 2012b, 806).

Most of what we currently know about deservingness stems from literature on deservingness of access to state welfare, largely in North America and wealthy European nations. Scholars have studied the impact of welfare recipients’ characteristics like race, ethnicity and gender on deservingness assessments by authorities and institutions (see for example, Little 1994, Gilens 1999 and Van Oorschot 2006). Others have explored public perception of responsibility towards individuals in need of social assistance and the impact of neoliberal influences on these perceptions and assessments. But how deservingness is conceptualized, understood and experienced in the health domain is not well known (Willen 2012a, Willen 2012b). Even less is known about the views of “those whose deservingness is being assessed,” as opposed to those of health care professionals, policymakers, institutions and the general public (Willen 2012a, 814).

In some of the emerging literature on the topic, Willen (2012a) defines conceptions of deservingness as “individual moral assessments of who deserves what and why” (814). She theorizes that deservingness can be understood as “the flip side of rights”: “whereas rights are presumed to have universal relevance, even when they are not universally enjoyed in practice, deservingness is always reckoned in relative terms” (814). Individuals typically assess others’ deservingness based on 1) their own sense of deservingness, 2) their social relation to other individuals (or groups) in question, and 3) presumed or actual characteristics of the other individual (or group). Conceptions of deservingness can in turn have subjective impacts (e.g. on self-perception, expectations of the state and society, and sense of responsibility for one’s health), as well as practical impacts (e.g. on access to the social determinants of good health, access to health care, and overall health status) (Willen 2012a, 819). In Tel Aviv, for example, popular stereotypes of foreigners as ‘criminals’ and ‘freeloaders’, sometimes cultivate “renegade moralities” among ‘unauthorized’ im/migrants (Willen 2012a, 819). Many im/migrants in this context recognize that being ‘unauthorized,’ they are outside the law, and thus should not expect any assistance from the state. They do not claim, nor do they feel entitled to, a ‘right to health care’. On the other hand, they also do not consider themselves ‘criminal’ or ‘amoral’ because they are often in such positions in order to provide food for their families, an education for their children or a dignified burial for their parents. As another example, Larchanché (2012) shows that while legally, ‘unauthorized’ immigrants in France have health care rights, in practice they face a myriad of “intangible obstacles” to realizing these rights, including precarious living conditions and a climate of fear and suspicion resulting from increasingly restrictive immigration policies (862). These obstacles have “powerful subjectivation effects” that negatively impact how immigrants (and their “interlocutors”) think about health-related deservingness (Larchanché 2012, 850). Larchanché (2012) refers to subjectivation as the relationship between discourse, government practices and subject-making (859). In the case of ‘unauthorized’ immigrants in France, she notes, exclusionary discourse not only helps to construct ‘unauthorized’ immigrants as undesirable political subjects, but it also negatively affects immigrants’ self-consciousness and self-esteem as individuals internalize stigmatizing representations of themselves. Discourses of

undeservingness, in particular, “produce” immigrants who feel undeserving as well as non-immigrants who think of immigrants and undeserving (Larchanché 2012, 862). Quesada (2012) adds that local conceptions of deservingness form part of the “cumulative (structural) vulnerabilities” that im/migrants can experience, including poor living and work conditions, low income, lack of health insurance, restricted mobility, etc. (895). In the case of Latino migrant labourers in the US, Quesada, Hart and Borgois (2011) note, “structural vulnerability” results from the combination of socioeconomic inequality, economic exploitation, cultural, gender and racialized discrimination, and “complementary processes of depreciated subjectivity formation” (339). The accumulation of these vulnerabilities can limit migrants’ agency in everyday life and in turn can also affect health care professionals who strive to provide them with services, and institutions, clinics and non-migrants that provide, receive, and pay for care (Quesada 2012, 895).

Furthermore, there is evidence to show that the subjective and practical consequences of conceptions of undeservingness can become “embodied” in both epidemiological and phenomenological respects (Willen 2011b, 809). From an epidemiological perspective, this means that conceptions of undeservingness may have visible impacts on individuals’ bodies; from a phenomenological perspective, it means that such conceptions may impact individuals’ lived experience (e.g. how they experience time and space, selfhood, or interaction with other people) (Nguyen and Peschard 2003, 455-456 and Willen 2012b, 808). For instance, individuals who internalize exclusionary arguments may be more likely to delay or forego care-seeking⁷ (Quesada 2011 and Chavez 2012). Anxieties associated with social (and/or political) exclusion, and with other factors such as precarious work and living conditions, poverty, language barriers and restricted social mobility, may also combine to produce chronic stress (Willen

⁷Notably, situations in which immigrants who are potentially eligible for health and social benefits refrain from using them, are popularly known as “voluntary withdrawal” or part of the “chilling effect” (a discouraging effect produced by restrictive or ‘threatening’ law) (Viladrich 2012, 826). While a great deal of health and social sciences scholarship has sought to understand the underlying causes of this phenomenon, only recently have scholars begun to pay attention to immigrants’ internalized sense of illegitimacy as one of these.

2012a). Not only does chronic stress have physiological ‘wear and tear’ consequences (Kaestner, Pearson, Keene and Generonimus 2009), but it can also further hinder individuals’ ability to attend to their health needs (Larchanché 2012). For example, ‘undocumented’ migrants in France sometimes “give up” on seeking health care because they have other, more pressing priorities like food and housing (Larchanché 2012, 852). Delayed or inappropriate care, psychological stress and/or structural vulnerabilities may then be most visibly manifested as “improperly healed fractures, festering abscesses, advanced cases of treatable infectious disease, or late stage cancers” (Willen 2012b, 806). Huffman, Veen, Hennik and McFarland (2012) illustrate this “pathogenic spiral” (Nguyen and Peschard 2003, 463) through their work with seasonal workers from Uzbekistan living as undocumented migrants in Kazakhstan. In this post-Soviet context with a high incidence of tuberculosis, ‘illegality’ and marginalization often renders Uzbek labour migrants particularly vulnerable to exploitative work conditions (e.g. informal contracts, overwork, poor work conditions), stressful legal situations (e.g. police harassment, brutality and extortion) and exclusionary health care contexts (e.g. negative health care worker attitudes and language or cultural barriers). Elements in each of these domains combine to become embodied as weakened immune systems and high risk of contracting tuberculosis, or as increasingly severe disease for individuals who already have it. This is despite the fact that tuberculosis treatment is free and universally accessible in Kazakhstan.

Beyond individual moral assessments, conceptions of deservingness shape and are shaped by historical, political, economic and socio-cultural factors (Sargent and Larchanché 2011, 346, Willen 2012a, 814, Sargent 2012, 856 and Biehl 2012, 261). As illustrated earlier, conceptions of deservingness may serve to delineate nations’ boundaries by reifying national identity ‘myths’ and self-perceptions (Fassin 2001, Ticktin 2011, Larchanché 2012 and Frecha 2015). But national identities, in turn, often depend on historical, political, economic and socio-cultural context. In the French and Canadian cases discussed, contextual influences included long-standing commitments to humanitarianism and the contemporary global shift towards border securitization and migrant criminalization. Goldade (2009) and

Goldade and Okuyemi (2012) add the similar case of Costa Rica, where a deep-rooted national commitment to health care as a universal right, combined with popular concerns about a growing population of unauthorized Nicaraguan migrants and a need for migrant labour, simultaneously produce and are reinforced by conceptions of migrants as undeserving and unwanted “Others”. Even more local conceptions of deservingness, such as those that influence clinical education and practice (including medical and nursing curricula) (Castañeda 2012 and Holmes 2012), scholarship in the health and social sciences (Viladrich 2012) or the mobilization of NGOs (Gottlieb, File and Davidovitch 2012), are complexly linked to “extrinsic factors” like geopolitics, national labour markets and ideologies about “the bounded social body and body politic” (Willen 2012a 814). In turn, they impact how clinicians view their patients, how scholars call attention to injustices, and how NGOs and activists defend and care for those who are excluded. Furthermore, Willen (2012b) suggests, they sometimes “recapitulate damaging forms of stereotyping and victim-blaming” (807).

Gaps in the deservingness literature

Much of the emerging literature focuses on ‘irregular’ im/migrants, as well as ‘low-skill’ migrant workers, as those whose health-related deservingness is most clearly contested (Willen 2012b, 806 and Sargent and Larchanché 2011, 350). Recent research, however, complicates the ‘regular’/‘irregular’ categories by highlighting that the choice to migrate is often a dynamic, contested and complex “dimension of displacement” (Yarris and Castañeda 2015, 65). In practice, such categories are more fluid than they are in public, political or academic discourse. Moreover, since im/migrant groups in general (not only ‘irregular’ im/migrants or migrant workers) are often at the center of judgments about deservingness, health-related deservingness warrants attention in ‘regular’ im/migration contexts as well (Sargent 2012). ‘Regular’ im/migration may include, for example, entrepreneurial im/migrants with business or work visas, family class im/migrants and students.

While most of the new literature on im/migration and health-related deservingness focuses on research settings in the United States or the European Union, Canadian contexts remain mostly uncharted. But as a country founded on principles of multiculturalism, humanitarianism, and universal health care (Mackey 2002, Thobani 2007 and Tolley, Biles, Andrew, Essess and Burstein 2012), and amid increasing population flows, border securitization and migrant criminalization trends worldwide, Canada faces many tensions between moral and political realms that are worth exploring. Between 2006 and 2015, under a Conservative Federal Government, Canada underwent significant im/migration and citizenship reform, including a shift towards temporary migration (with the Temporary Foreign Worker Program [TFWP]), an emphasis on economic priorities at the expense of immigrants and refugees and their families, increasing barriers to citizenship, as well as an increasingly restrictive refugee determination system (Canadian Council for Refugees [CCR] 2014a). Further changes and/or change reversals are expected with the beginning of a new Liberal Government led by Justin Trudeau in 2015 (Liberal Party of Canada 2015). Canadian contexts therefore offer unique opportunities for exploring how local “reckonings” (Willen 2012a) of health-related deservingness are shaping, and being shaped by, these changes.

Only following recent im/migration reform have we seen a surge in Canadian literature and scholarly commentary on health care providers’ perceptions of im/migrants’ and refugees’ access to care (see for example, Caulford and D’Andrade 2012, Raza, Meb, Redwood-Campbell, Rouleau and Berger 2012, Vanthuyne, Meloni, Ruiz-Casares, Rousseau and Ricard-Guay 2013, Wahoush 2013 and Molnar-Diop 2014). As in other contexts around the world, these health care professionals and scholars find subtle (and often unintentional) negative moral assessments of deservingness against im/migrants across clinical education and practice, as well as in political and public discourse. Little has been said, however, about im/migrants’ (‘irregular’ or otherwise) own understandings of ‘the right to health care’, their individual experiences of entitlement, access and deservingness, or how they negotiate these in everyday life. Moreover, the Canadian literature that addresses judgments and attitudes about im/migrants’ access to health care tends to focus on major im/migration hubs, such as Toronto and the Greater Toronto Area

(GTA) (Caulford and D'Andrade 2012, Raza et al. 2012 and Wahoush 2013), Montreal (Vanhuynne et al. 2013) and Vancouver (Khoen 2009). In these contexts, a well-studied myriad of socio-cultural and economic barriers, such as financial hardship, lack of employment, refugee status, racial/ethnic discrimination and mental health, intersects with judgments and attitudes about im/migrants' access to health care. Whether or not this is the case, and what the im/migration and settlement experience is like in smaller urban centres and rural/remote settings, is less clear. In Central and Northern Ontario especially, such settings are not only receiving a growing number of im/migrants, but they are also increasingly looking to im/migration as a potential contributor to economic stimulation and development, and labour diversification (Tolley et al. 2012, 2). These settings constitute a dynamic and unexplored piece of the Canadian im/migration landscape and may thus provide significant insight into the emergence and impact of local "reckonings" (Willen 2012b) of health-related deservingness.

Looking forward, experts suggest that ethnographic research is likely to be particularly fruitful in the study of im/migration and deservingness because it can help us to situate normative and largely philosophical approaches to ethics and morality in social practice, and to re-think and re-formulate deservingness debates (Sargent and Larchanché 2011, Fassin 2012a and Willen 2012b). This may be, for instance, by elucidating everyday patterns of deservingness reasoning and their complex impact, or by 'humanizing' im/migrant individuals and giving them a voice in the deservingness discourses that concern them (Willen 2012a, 820 and Sargent 2012, 856). In addition, ethnographic methods offer an alternative to the many clinical, public health and socio-economic approaches that are often used to explore links between (social, cultural, political and/or economic) inequality and health across im/migration contexts (Nguyen and Peschard 2003, 462). While the emerging literature shows that some scholars in the US and Europe are beginning to respond to this call for further social scientific (especially ethnographic) work, Canadian research, as well as research from and in the Global South, lag behind.

An “ethical turn” in anthropological theory

The contemporary centrality of moral issues within and beyond academia and across the globe, has shifted anthropological theory to focus more explicitly than in the past on questions of morality and ethics of philosophical origins. To some extent, anthropologists have always touched on mores and norms, often straddling the dialectic between descriptive and prescriptive work; “between analyzing what is considered to be good and asserting what is good” (Fassin 2012b). This is perhaps clearest in the age-old debate of universalism versus relativism (Fassin 2012b). Mostly indirectly, much of this past work reflects a Durkhemian paradigm and Kantian genealogy of deontological ethics, whereby morality is considered an external/social set of values and norms that directs individual action (Zigon 2007, 148 and Fassin 2012a, 6-7).

Over the last few decades, however, there has been a more pointed investment by anthropologists and other social scientists into the field of morals and moralities (Fassin 2012b). Moreover, there has been a shift in focus from the collective to the individual and from the social to the experiential, aligning closer to a Foucauldian paradigm of subjectivation and an Aristotelian genealogy of virtue ethics (Fassin 2014, 429). That is, considering ethics as an inner process – a questioning about what a good life is – that guides action (Fassin 2012a, 7). For example, Mahmood (2005), Hirshkind (2006) and Simon (2009), explore religion in diverse contexts as “disciplinary exercises and reflexive practices which produce ethical subjects,” rather than as cultural systems external to the individual (Fassin 2012a, 7-8 and Fassin 2014, 430). Lambek (2010) and Das (2006 and 2012) consider ethics as “ordinary” and potentially intrinsic to everyday language and action, in India and Madagascar, respectively. Somewhat similarly, Sykes (2009) explores how individuals in New Ireland reason through common moral/ethical contradictions in everyday lives. Jason Throop (2010 and 2012) takes a phenomenological approach in his work on suffering in Micronesia, exploring the role of sentiments (including emotions, motives, moods, etc.) in configuring and being configured by moral/ethical assumptions (Throop 2012, 159 and Fassin 2014, 430). And, based on his work in Russian contexts, Zigon (2007) introduces the theoretical framework of

“moral breakdown” as a means of studying morality. He suggests focusing on momentary collapses in unreflective, everyday “moral dispositions” that require individuals to take more conscious ethical action in order to continue living peacefully alongside other individuals.

In a recent compilation of their latest work, however, these experts agree that moving forward there are a couple of key gaps to consider (Fassin 2012a). The first relates to how morality and ethics have been/are generally treated in anthropological work. Beyond definitional inconsistencies, social scientists tend to consider morality and ethics (in theory) as autonomous from each other; the former as “the respect of rules” and the latter as “the realization of the self” (Fassin 2012a, 9). We are reminded that empirically, however, it is much more difficult isolate the two, since human action and experience are so complex. In addition, they suggest, it may also be fruitful to ask questions about how potential consequences of moral action and ethical practices impact morality and ethics (Fassin 2012a, 8). This, in turn, implies a “politicization” of morality and ethics, more consistent with contemporary research contexts.

In response to these gaps, Didier Fassin proposes a singular and pioneering approach to the study of morals and moralities: *critical moral anthropology* (Fassin 2012a). The defining feature of this approach is that it is critical, and therefore, often political. One of its major theoretical objectives is to interrogate how the macro-social (i.e. policies and politics) and the micro-social (i.e. beliefs and practices) develop and interact in moral debates. In the theoretical dimension, this approach requires critical inquiry into the historical, socio-cultural, political and individual-level roots and impact of moral debates. In the empirical dimension, it requires study of the “moral work”, or the ‘real-life’ beliefs, values, reasoning, actions, etc., of divergent stakeholders in those debates. Importantly, Fassin notes that critical inquiry does not mean criticism (Fassin 2012a, 15). From a theoretical perspective, critique signifies an awareness of “the moral values and ethical principles that constitute our common sense”; not only for the sake of relativity, but more importantly, because this allows us to question morals, morality and ethics (our own and others’) (Fassin 2012a, 15). Empirically, critique requires an understanding of the fact that

in the ‘real’ social world, morality and ethics are intricately linked with each other and with other domains, in particular the political. Epistemologically, “critique involves the anthropologist as subject”, since the researcher may be “morally engaged” in the moral issue(s) in question (Fassin 2012a, 15). Reflexivity is therefore of utmost importance. Finally, from a political perspective, critique implies attention to how morality and ethics are “deployed” in reasons, justifications, actions and consequences in the contemporary world. Fassin adds that ethnography is “the method of choice” to best “apprehend the complexity and impurity of morals and moralities in contemporary societies” (Fassin 2012b and 2014).

Fassin has employed the critical moral anthropological approach in his work on the politics of morality in international humanitarianism and asylum granting (Fassin 2013). In particular, he has studied how various institutions (including police, justice and health care) use moral categories and justifications to disqualify or absolve, exclude or include, and mistreat or respect, minority groups like immigrants, refugees and asylum-seekers in France (Fassin 2012b). In alignment with his proposed approach, he has focused on how public discourses and policy, as well as historical and social context, influence institutional and professional practices. Thanks to this, he has helped to elucidate the complex impact of France’s “illness clause”, as well as the “interlinked scales and intertwined domains”⁸ of France’s asylum-granting system (see for example Fassin 2001, 2009 and 2011). The critical moral anthropological approach has also influenced various scholars of deservingness (see for example Ticktin 2011, Willen 2012a and 2012b, Sargent 2012, Larchanché 2012 and Castañeda 2012), and has become a guiding framework for a research program called *Towards a Critical Moral Anthropology*, which brings together sociologists, anthropologists and political scientists in the US and Europe (Fassin 2012b). As such, it is the guiding theoretical framework for this study, focusing attention on the complexity of links between the macrosocial and microsocial in producing local “reckonings” of health-related deservingness.

⁸This refers to the ways in which exclusionary rhetoric regarding asylum-seekers and refugees is increasingly infiltrating the everyday work of local bureaucracies (e.g. policy, justice and health care), leading to increasingly lower acceptance rates, and in turn reinforcing the same exclusionary rhetoric, and justifying accompanying policy.

Complementary analytical tools

Intersecting the study of morality, ethics and phenomenology, Zigon (2012) offers the concept of *narratives*. Analysis of narratives has become increasingly popular in anthropology, because narratives – whether stories or narrative interactions – are widely seen as one of the ways in which individuals make and/or share meaning in their lives. Therefore, they are likely to provide a telling depiction of social life. Within the study of morality and ethics, however, Zigon (2012) suggests moving beyond ‘reading’ narratives as meaning-making articulations, to understanding them instead as self-reflected articulations of “the embodied struggle to morally be with oneself and others in the social world” (205). That is, rather than carriers of meaning or a path to mutual understanding, narratives are an end in themselves – they are words, utterances, acts and gestures that allow individuals to regain “moral comfort” in moments of “moral breakdown” or moral discordance in a particular social context and with their interlocutors (Zigon 2012, 205). As such, they are also articulations of individuals’ “own moral subjectivity, their own understanding of institutional and other public discourses of moralities, and the ethical practices they perform” (Zigon 2012, 206).⁹ Analysis of narratives, then, is important to the study of morality and ethics, because it reveals how individuals conceive of their own life and experiences and helps to describe individuals’ moral worlds (Zigon 2012, 206). In this study, however, I will not do a comprehensive analysis of narratives. Instead, Zigon’s concept will help me to describe and understand the things that individuals say and do to ‘feel’ moral in contexts in which they are often told or shown otherwise.

⁹To illustrate the narratives concept, Zigon uses an example from his research on moral experience in Moscow as a post-soviet global city. He recounts a conversation between two young women who are best friends. When describing their relationship and the ways in which they deal with minor “transgressions” against each other (e.g. being late for a meeting), they each claim to accept those transgressions because they “understand” each others’ differences (Zigon 2012, 211). Then, when asked what they mean by ‘understanding’, they disagree and quickly change the subject of the conversation. Zigon interprets this latter portion of the conversation as a moment of “moral breakdown”, and an effort by each of his informants to return to being “comfortably” with each other (Zigon 2012, 214). Moreover, he realizes that the women were not speaking of a “meaningful understanding” of differences, but rather, of an acknowledgement of differences that allows them to “survive” alongside each other (Zigon 2012, 215-217).

In addition, merging morality and ethics with borders and migration, Heyman and Symons (2012) remind us that policies, discourse and practices around state borders and migration often hinge on reductive and absolutist imaginations of ‘a border’, rather than on the realities and diversity of migration contexts. Particularly in political and public imaginaries, ‘the border’ symbolizes the sovereign, territorial polity and tends to be thought of as a filter that protects the “good and safe” from the “bad and threatening” (Heyman and Symons 2012, 540). In such imaginations ‘the border’ does not only protect those inside the polity from those on the outside. It also helps to manage ‘undesirables’ within national interiors, by justifying extended, border-like sites and practices like international airports and transportation sites, migrant detention centres and policing. Reductive and absolutist imaginations of ‘the border’ preclude recognition of borders and migration as “messy” sites of experience, activity and human connection, and of the “ambiguity and subtlety” of moral issues and moral subjectivities on the ground (Heyman and Symons 2012, 543). In turn, this helps to draw attention away from those on ‘the outside’, and to deny responsibility for or obligation to transnational flows, relations or connections (e.g. postcolonial, geopolitical struggles) (Heyman and Symons 2012, 546). As an alternative, Heyman and Symons propose complicating ‘the border’ by studying *borderlands* – diverse border locations and experiences – with a focus on the everyday “moral reasoning and related actions that people engage in relative to borders” (540). The *borderlands* concept is important to this study for various reasons. First, it highlights the importance of understanding the everyday realities of borders and migration, and so lends support to this study’s main objective – exploring everyday, local reckonings of health-related deservingness among im/migrants. Second, thinking about *borderlands* reminds us that everyday interactions and relationships between migrants and non-migrants are not limited to border crossings, and need not be defined by immigration documentation or lack thereof. This, in turn, underlines the dynamic and malleable nature of social membership, and perhaps also of deservingness, depending on particular contexts, relations and situations. Finally, the *borderlands* concept calls attention to potential “new patterns of moral obligation” (540) that may emerge from everyday interactions and relationships between migrants and non-migrants. That is, if we are to examine and participate in these “emergent

relations”, whether in academia or in everyday life, they should be recognized and valued, and “should entail steps toward inclusion and membership” (552).

Conclusion

In this chapter I aimed to situate my study within the contemporary literature on im/migration and global health. At the broadest level, the main objective of the study – to explore local conceptions of health-related deservingness among im/migrants in Sault Ste. Marie, Ontario – emerges from a few key trends in im/migration and global health research. On one hand, there is increasing attention to the politics of entitlement and exclusion as a key determinant of health vulnerabilities and access to health care. As illustrated throughout the chapter, morality and the human body are central to these politics. Simultaneously, there also seems to be a marked need for multi-level (local, state and global) and multi-dimensional approaches to understanding how im/migration, health and the politics of exclusion and entitlement are produced. Scholars are now calling for further investigation of im/migrants’ experiences of health-related deservingness as reflective of, and also as a more focused way of understanding the contemporary politicization of im/migrants’ health and health care.

My study responds to these trends in several ways. By taking a local, ethnographic approach to health-related deservingness, it helps to situate contemporary deservingness debates in individual experience and social practice, and provides insight into the ‘real-life’ (subjective, practical and/or embodied) impact of such debates (i.e. on health and health care). By focusing on a relatively unexplored Canadian context it helps to address the dearth of research pertaining to this region, while also pioneering investigation of how conceptions of health-related deservingness emerge alongside new im/migration landscapes. Finally, a critical moral anthropological lens ensures a holistic perspective, linking local “reckonings” to a historical, socio-cultural and political context, and thereby also to a more global politicization process.

CHAPTER 2: Ethnographic Context

The Canadian im/migration landscape & influences on im/migrants' deservingness

Willen (2012a) notes that assessments of who deserves what and why, and resulting conceptions of deservingness, shape and are shaped by historical, political, economic and socio-cultural contexts, as well as by individual values and commitments (814). In turn, they influence discourse and practice in policy-making, institutions, the media and the lives of citizens and non-citizens. In line with Willen's point, this section presents an overview of the historical, political, economic and socio-cultural influences on conceptions of im/migrants' deservingness in Canada. The interactions among these different contextual dimensions and how they play out in the lives of im/migrants throughout Canada are undoubtedly complex, dynamic and ever-changing. Nevertheless, acknowledging and understanding them are essential to making informed observations and conclusions about the individual deservingness experiences of im/migrants in Northern Ontario.

Canada on the global stage

In the age of globalization, blurring national boundaries and increasing mobility of people, information, technology, products and capital, Canada's im/migration context cannot be considered in isolation. Im/migration policies, debates and experiences in Canada influence and are influenced by a myriad of international, transnational and supranational connections and "flows" (Li 2003). Some of these are briefly outlined in this section, with particular attention to how they might affect local understandings of im/migrants' deservingness.

Canada is often said to be a nation of im/migrants – a major destination for large numbers of international im/migrants, who have played a key role in shaping the country's social, political, economic and cultural fabric over the last century and a half (Li 2003, 8, Walsh 2008, Kobayashi, Teixeira and Li 2012, xiv and Reitz 2014, 88). In fact, Canada has the highest proportion of foreign-born residents among

G8 countries (20.6 percent) and one of the highest im/migration rates in the world (Kobayashi, Teixeira and Li 2012, xvi and Statistics Canada 2015). Recent UN estimates showed that of 214 million international im/migrants worldwide, approximately 7.2 million settled in Canada, making it the third largest im/migrant receiving nation in the world (Kobayashi, Teixeira and Li 2010, xvi). The majority of im/migrants in Canada come from countries in Asia and the Middle East. The Philippines is the most common country of origin (Statistics Canada 2015).

Among the states considered “traditional nations of immigration”, including Australia and the US, Canada can be said to have most consistently pursued a “high-immigration policy” (Reitz 2014, 89). Since the end of the Second World War, Canadian im/migration policy has increasingly emphasized large-scale recruitment of highly skilled workers, and aimed to facilitate integration into society by providing access to citizenship, language training and other settlement services (Walsh 2008, 792 and Reitz 2014, 89). Australia has taken a similar approach but received slightly lower numbers of im/migrants, while in the US, im/migrants have generally been sought out only as temporary workers (even “denizens”) (Walsh 2008, 794). In light of increasingly restrictive global im/migration schemes and border controls in the 21st century, Canada’s sustained commitment to large-scale im/migration and settlement can be considered exceptional (Walsh 2008, 793). Walsh (2008) suggests that Canada is considered a “model country”, whose im/migration policy is increasingly watched and emulated by other states. It is a country admired for its consistent success in admitting and incorporating large im/migrant cohorts, and for its contemporary skills-based im/migrant selection system, which aims to fulfill principles of control and fairness domestically and internationally (Walsh 2008, 793). The United Kingdom, Germany, France, the Netherlands, the United States, New Zealand, Singapore, Malaysia, Iceland, Italy, Finland, Ireland and Japan have all either pursued or implemented models of im/migrant selection similar to that employed in Canada. Moreover, since incorporating the *Immigration Act* (S.C. 1976-7, c. 52) and the *Canadian Multiculturalism Act* (R.S.C., 1985, c. 24 (4th Supp.)) into its

im/migration policy, to reduce discrimination and racial bias, Canada has come to be regarded as one of the most generous states in the world (Mackey 2003, Thobani 2007 and Walsh 2008, 797).

Li (2003) suggests, however, that like with many other wealthy nations around the world, Canadian im/migration policy and debates do not only depend on humanitarian considerations but also on self-interest, and on utilitarian notions about the value and merits of im/migrants (11-13). In the contemporary global context of economic globalization, capitalist expansion, digitalized economies and aging workforces, im/migrants with human and financial capital are in greatest demand, and therefore, most mobile. But im/migrants tend to move from less developed to highly developed regions, allowing wealthy nations such as Canada to benefit most from the transfer of human and financial resources (Li 2003, 176 and Walsh 2008, 796). At the same time, globalization also links disadvantaged regions to the global economy helping wealthy nations to “drain” their human capital, damaging traditional economies, and marginalizing and displacing individuals and families tied to them (Li 2003, 12). Moreover, the im/migration policies of wealthy nations, which generally benefit, tend to reflect and deepen these global inequalities. While there is intense competition among such countries for im/migrants with professional expertise, highly specialized skills and financial capital, those who are marginalized and displaced are deemed unwanted social and financial burdens on receiving societies (Li 2003, 7).

Undoubtedly the links between globalization, im/migration and global inequality are more complex than presented here. As a starting point, however, it is important to highlight that Canada’s advantageous position in these global migration “flows” (Li 2003, 176) impacts how it approaches and assesses “the merits of migration” (Li 2003, 7). Li (2003) further suggests that im/migration is perceived as ‘worthwhile’ in wealthy nations like Canada, if it both meets humanitarian objectives and benefits the receiving society (176). Importantly, Walsh (2008) also notes that Citizenship and Immigration Canada (CIC) has repeatedly pinpointed globalization as “one of the most significant trends affecting immigration [policy]” (CIC 1998, 1), and skilled im/migration as essential to Canada’s competitive edge in a knowledge-based economy (804).

The social and economic role of im/migration in nation-building

The humanitarian and utilitarian narratives that underlie Canada's position on the global stage are product of a long history of using immigration as a key component in nation-building and socio-cultural development. Im/migration has often served as a means to address challenges of settlement, labour shortages, and economic and infrastructure development (Li 2003, 14-15, Walsh 2008 and Reitz 2014, 89). The first waves of im/migration to Canada arrived in the seventeenth century, following English and French colonization, settlement and growth of the fur trade. The new colony attracted craftsmen, artisans, traders, and missionaries – mostly English and French – who fled desperate political and economic conditions in their home countries and looked for new economic opportunities in Canada. Despite extensive conflict between the two settler groups, the *Constitution Act* of 1791 and confederation in 1867 institutionalized joint governance of the emerging nation, establishing Britain and France as “charter” groups – “the first outside groups to settle in a previously sparsely populated territory” – and the “preferred races” (Porter 1965, 60, Li 2003, 16 and Thobani 2008, 12). As such, the two groups would “set the conditions for entry and the rules of accommodation for subsequent immigrant groups” (Porter 1965, 60 and Li 2003, 16).

Beyond confederation, im/migration trends and the role of im/migration in the emerging nation were governed by state policy “regarding the types of people who would be accepted as desirable immigrants” (Li 2003, 17). Canadian im/migration policy – and by extension, the categories of desirable and undesirable im/migrants – since the late nineteenth century evolved over four key phases. During the first phase (1867-1895), Prime Minister Macdonald's national policy included an open-door im/migration scheme favouring those of European origin, particularly those from Britain (Kelley and Trebilcock 2010, 110). The objective of this strategy was to recruit workers in order to increase domestic production and complete the transportation infrastructure that would open up the West for agricultural settlement.

In the second phase (1896-1914), the Canadian state looked to massive im/migration for agricultural settlement and production. By then, the numbers of im/migrants arriving from the British Isles and Northern European countries were lagging, so Eastern and Southern European im/migrants, including Poles, Ukrainians and Hungarians were also welcomed (Kelly and Trebilcock 2010, 72-7). Non-white im/migrants, however, were restricted from entry into the country. They were considered by Manpower and Immigration Canada “unlikely to assimilate” due to their perceived racial and cultural differences (Li 2003, 19). Chinese im/migrants, for example, were deterred with a head tax of \$50 to \$500 per newcomer, while East Indians were required to have travelled directly from their home country in order to be admitted (Li 1998 and Li 2003, 19). Still, over 3 million im/migrants came to Canada during this period, sparking a “wheat boom” and intensive industrialization (Kelly and Trebilcock 2010).

Between 1915 and 1945, the First and Second World Wars and the Great Depression hampered im/migration (Kelly and Trebilcock 2010, 442). Foreigners were still being recruited for land settlement, and increasingly, to meet the demands of war-related industries and to keep the economy afloat during times of recession. Those from Britain, the US, and North and Central Europe were still favoured; those from Southern and Eastern Europe tolerated; and now, Jews, in addition to non-white im/migrants were unwelcome (Li 2003, 21 and Kelly and Trebilcock 2010, 442).

Little changed during the first two decades after the Second World War. Although im/migrants were required to fill major labour shortages in post-war reconstruction, in 1947, Prime Minister Mackenzie King stated: “the people of Canada do not wish, as a result of mass immigration, to make a fundamental alteration in the character of our population. Large-scale immigration from the Orient would change the fundamental composition of the Canadian population” (Abu-Laban and Gabriel 2002, 40, Li 2003, 23, CIC 2006a and Walsh 2008, 795). But the perceived “quality of immigrants, in terms of their occupational and educational qualifications,” had declined with the increase in unskilled im/migrants admitted from Southern and Eastern Europe (Li 2003, 23). At the same time, post-war economic recovery and subsequent industrial expansion in Western Europe and the US increased competition for European

skilled labour; and in combination with the post-war international codification of human rights regimes, put pressure on Canada to modify its Eurocentric im/migration policies and still maintain some control and selectivity (Li 2003, 25, Walsh 2008, 796 and Mackey 2005, 66). In 1967, this ushered in Canada's (and one of the world's) first comprehensive system of im/migrant selection, known as the points system. This new system "sorted migrants into three distinct groups or classes: the independent or skilled class, the family class, and the humanitarian class" (Walsh 2008, 797). Family class migrants were assessed based on close family ties with citizens and permanent residents of Canada, and refugees on humanitarian grounds. Independent or skilled migrants, however, had to achieve a minimum of 50 out of 100 points – awarded for age, occupational demand, education, work experience, language ability and adaptability – to be granted entry and potential citizenship (Walsh 2008, 797-798). The point system signaled a commitment to humanitarian im/migration and family reunification (Walsh 2008, 796). It also reflected an increasing attention to the importance of advanced manufacturing and specialized services as critical economic sectors and to the economic significance of im/migrants and im/migration policy. A White Paper on im/migration published at the time captured this interest stating: "Canada has become a highly complex industrialized and urban society...if [migrants] entering the workforce...do not have...the training to do the kinds of jobs available, they will be burdens rather than assets" (CIC 2006b, Canadian Museum of Immigration at Pier 21 2016 and Walsh 2008, 797). The temporary foreign worker program (TFWP) was also introduced in 1973 to attract individuals with highly specialized skills, such as academics, business executives, doctors and engineers who could help fill gaps in the Canadian labour force (Reitz 2014, 97-98).

Economically-guided im/migration policy became particularly important for Canada in the early 1980s, as a means of coping with a global economic crisis. In response to massive economic stagnation, high unemployment and mounting government debt, Canada (and various other capitalist states) sought alternatives to using fiscal policies to stimulate the economy (Li 2003, 29). New growth strategies included global economic integration, the dismantling of social-welfarism and neoliberalism (Walsh

2008, 798). In this context, im/migration and im/migration policy became an opportunity to: “forestall the shrinking and ‘graying’ of the population, establish cross-national labour circulation for affluent and highly-skilled migrants,” and align with increasingly popular models of neoliberalism (Walsh 2008, 798). One of the first indicators of this policy shift was the expansion of the points system to include a business sub-class, as part of the independent or skilled im/migrant class (Walsh 2008, 800 and Li 2003, 26-27). This new sub-class facilitated entry for entrepreneurs, self-employed people and investors, and thereby made it easier for im/migrant capital to move into Canada. At the same time, for economic im/migrants outside of the business class, and for those in the family or humanitarian streams, the im/migration scheme became more restrictive (Walsh 2008, 800). For economic im/migrants outside of the business class, the number of points required to secure entry into the country increased from 50 to 66 out of 100, and greater importance was given to human capital and work experience than to noneconomic criteria, such as family relations in Canada or intended location of settlement. Moreover, the ratio of skilled to family and humanitarian immigrants admitted was inverted (CIC 2005). Independent or skilled immigrants were prioritized, constituting 60 to 70 percent of the total immigrant inflow, while the family and humanitarian categories started to be capped at 30 to 40 percent (CIC 2005 and Walsh 2008, 803). This helped to entrench “economic self-sufficiency as a measure of immigrants’ worth” (Li 2003, 43) and began to position those in the family and humanitarian categories as a social/welfare/economic cost in comparison (Abu-Laban 1998, 205 and Li 2003: 23)

As a young nation, however, Canada had to balance growing economic interests with efforts to build and maintain a national identity. The *Immigration Act* (S.C. 1976-7, c. 52) and the *Canadian Multiculturalism Act* (R.S.C., 1985, c. 24 (4th Supp.)) formally outlined a federal im/migration and settlement program, and symbolized Canada’s transition from a colonial settler state to a liberal-democratic one (Thobani 2007, 23). Most importantly, Canada’s im/migration program came to be seen as “amongst the most humanitarian and compassionate in the world” (Thobani 2007, 72). These changes elevated the Canadian state domestically and internationally, while at the same time drawing attention

away from English-French Canada disputes, the continued marginalization of Aboriginal peoples and the ongoing construction of the non-European im/migrant as “a cultural stranger to the national body” (Mackey 2005, 76 and Thobani 2007, 23). As cornerstones of the modern Canadian identity, multiculturalism and im/migration ideals also framed the development of the *Canadian Charter of Rights and Freedoms* (1982) and the *Canada Health Act* (R.S.C., 1985, c.C-6) (Mackey 2005, 15).

Mackey (2003) further suggests that in Canadian identity narratives and nationalist mythologies embedded in these im/migration and citizenship policies, Canadians of the “preferred races” have generally come to be presented as “Benevolent Mounties” (23). This term describes law-abiding, compassionate and caring citizens, committed to the values of diversity and multiculturalism (Mackey 2002, 15). At the same time, she notes, non-European im/migrants and aboriginals are often presented as chaotic, criminal and sometimes even deadly. Thobani (2007) adds that subject formation within Canadian society has come to be “triangulated” (15). The national/citizen, with his/her responsibility to protect “national well-being” is the apex, while “the immigrant receives tenuous and conditional inclusion; and the Aboriginal [is] marked for loss of sovereignty” (Thobani 2007, 15).

Mackey (2003) describes Canada’s im/migration history as “an essential, and yet necessarily flexible, aspect of nation-building” (47). Beyond their economic roles as settlers, workers and consumers, different groups of im/migrants have – in different time periods and in different ways – embodied the socio-cultural boundaries of the nation. Grounded in this historical context, the humanitarian and utilitarian narratives common in present immigration policy, debates and experiences become clearer.

Contemporary im/migration policy and politics

An emphasis on the economic and socio-cultural benefits of im/migration continues to frame immigration policy in Canada – now perhaps more than ever. The *Immigration and Refugee Protection Act (IRPA)* (S.C. 2001, c.27) is the key piece of legislation pertaining to im/migration and refugee

protection in Canada. The IRPA revamped and replaced the *Immigration Act* (S.C. 1976-7, c. 52) and all amendments that had been made to it until the early 2000s (some mentioned earlier) (Li 2003, 26).

Different from the *Immigration Act*, the IRPA contains a modified points system and distinguishes between im/migration and refugee protection. A brief overview of key components is presented below.

The IRPA is also supported by the *Canadian Multiculturalism Act* (R.S.C., 1985, c. 24 (4th Supp.))¹⁰, and the *Citizenship Act* (R.S.C., 1985, c.C-29)¹¹.

Under the IRPA, there continues to be a points system with three main streams of im/migration to Canada: the economic stream, the family stream and the humanitarian stream (Bragg 2013, 4-5). Within each stream, there are various programs that prospective im/migrants can apply to in order to be admitted into the country. Furthermore, the Act separates those who are *permanent* im/migrants, called landed im/migrants¹² or permanent residents, from those who are considered *temporary* im/migrants, including visitors, students and temporary foreign workers (2001, c. 27, s. 3.1). The former group is selected mainly through the economic and family streams, and is entitled to settlement programming including language training, health care and social services, as well as human rights and equality protection (Biles and Winnemore 2007, 51 and Reitz 2014, 94). They may also apply for Canadian citizenship through naturalization after three years of living in Canada (Li 2003, 44). On the other hand, temporary im/migrants have limited or no government-funded access to health care, social services or other im/migration and settlement resources, depending on their visa.

¹⁰Among its main objectives, the *Canadian Multiculturalism Act* aims to “recognize and promote the understanding that multiculturalism reflects the cultural and racial diversity of Canadian society and acknowledges the freedom of all members of Canadian society to preserve, enhance and share their cultural heritage”.

¹¹In 1977, the *Citizenship Act* replaced the original *Canadian Citizenship Act* (1947). The original Act separated Canadian citizens from British subjects, established who could become a citizen and outlined provisions for loss of citizenship, as well as special privileges for British subjects. The new Act set forth a more equitable statute, eliminating the latter privileges and allowing for dual citizenship. This Act changed very little until the most recent amendment to date – Bill C-24, or the *Strengthening Canadian Citizenship Act* – which came into force on June 11, 2015 (CIC 2015a).

¹²Landed immigrant is an older term, but one that may still be used in immigration processing procedures.

In an altogether separate category, those who enter Canada as asylum seekers are legally considered *refugee claimants* (CCR 2010). Refugee claimants can apply to im/migrate upon arrival on Canadian soil. Those who are granted *refugee*¹³ status are entitled to specific settlement programming, including the Refugee Resettlement Assistance Program (RAP) and an income support program that also provides reception, temporary accommodation and basic orientation services (Biles and Winnemore 2007, 52). They can also eventually apply for permanent residency (CCR 2010). In addition, a select number of refugees per year may apply to im/migrate from abroad and be resettled¹⁴ by the Federal Government (Government-assisted refugees [GARs]), or they may be privately sponsored by an individual, family, or organization (CIC 2015b and CIC 2016b).

Humanitarian and utilitarian interests are evident among the IRPA's main objectives and provisions. For example, with regards to im/migrants, the first objective is "to permit Canada to pursue the maximum social, cultural and economic benefits of migration" and the third is "to support the development of a strong and prosperous Canadian economy, in which the benefits of immigration are shared across all regions of Canada" (S.C. 2001, c. 27, s. 3.1a and c). With regard to refugees and refugee claimants, the Act's third objective is "to grant, as a fundamental expression of Canada's humanitarian ideals, fair consideration to those who come to Canada claiming persecution" (S.C. 2001, c. 27, s. 3.2c).

In tune with contemporary global and economic trends, the IRPA also updated the points system to select skilled workers with even greater human and financial capital than in the past. While the three streams of im/migrant selection remained mostly unchanged, the modified points system assigned more weight to education, language and occupational factors (Li 2003, 39-41). Points were also added for

¹³In Canadian law, refugees are those who meet the 1951 Geneva Convention definition relating to the Status of Refugees (CCR 2010). By this definition a refugee is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country" (United Nations High Commissioner for Refugees [UNHCR] 2016)

¹⁴Resettled refugees are determined to be refugees by the Canadian government before they arrive in Canada, and become permanent residents upon arrival (CCR 2010).

spouses' education and occupation, and the minimum total number of points required to be granted entry increased to 75 out of 100. But the ratio of economic to family and humanitarian im/migrants remained high.

Recent amendments to the IRPA, however, place ever more emphasis on the economic benefits of im/migration for Canada, and are said to represent the most significant revisions to the Canadian model for im/migration and citizenship yet (Reitz 2014, 89). Following the election of a Conservative minority under Stephen Harper in 2006, the Federal Government began to introduce substantial im/migration policy changes at an unprecedented pace (Reitz 2014, 89 and Alboim and Cohl 2012, 2). According to various government speeches and announcements, the objectives of these changes were to: 1) improve relatively poor economic outcomes (e.g. employment) for new cohorts of im/migrants compared to past ones; 2) increase the short-term benefits of im/migration to the Canadian economy; 3) address backlogs in the im/migration system and enhance the efficiency of im/migrant selection and refugee determination processes; and 4) strengthen border control, prevent fraud and minimize abuse of the immigration system (Reitz 2014, 89 and Alboim and Cohl 2012, 3). While the three streams of im/migration, as well as a relatively high permanent im/migration objective remain in place, Canada's approach to im/migration has changed in fundamental ways.

In 2008, one of the first and perhaps most impactful changes allowed the Minister of Citizenship, Immigration and Multiculturalism to give instructions (legally called Ministerial Instructions) directly to im/migration officers, rather than going through parliamentary process before making major changes to im/migration policy (Parliament of Canada n.d., Bragg 2013, 7 and Alboim and Cohl 2012, 3). More recently, the government also started using omnibus legislation – long and complex bills– to make changes to the IRPA (Bragg 2013, 7). In combination with Ministerial Instructions, omnibus bills facilitated large and fast policy changes, and as Alboim and Cohl (2012) suggest, weakened democratic and parliamentary processes (12). Over Stephen Harper's term (2006 to 2015), IRPA provisions for almost all categories and programs of entry into Canada were changed (Alboim and Cohl 2012).

In the economic stream of permanent im/migration, the Federal Skilled Workers Program (FSWP) accounts for roughly 37 percent of economic im/migrants to Canada (Government of Canada 2012a and Bragg 2013, 12). This program became more restrictive by reducing the number of acceptable occupations for application, increasing English/French language requirements, giving preference to younger workers with Canadian experience, and requiring that professionals have their credentials evaluated before they arrive in Canada (Bragg 2013,12, Alboim and Cohl 2012, 22 and CIC 2015c). These changes correspond with recent research on factors that improve im/migrants' labour market success and adaptability (Reitz 2014, 97 and CIC 2015c). Moreover, potential applicants to this program must now send a letter of interest to the Canadian government and be chosen by a Canadian employer to be granted an opportunity to apply. The latter change is to prevent an application backlog and to ensure that newcomers are filling workforce gaps efficiently (Bragg 2013, 12, Alboim and Cohl 2012, 22 and CIC 2015c). Meanwhile, in the family stream, a new cap of 5,000 per year on the total number of parents and grandparents that can be sponsored to come to Canada by permanent residents was introduced. This change was justified as a way of ensuring that elderly im/migrants do not drain the Canadian welfare system or abuse Canada's generosity (Bragg 2013, 16 and Fitzpatrick 2013). In line with this rationale, the qualifying criteria for those who want to sponsor an adult (18+) dependent also became more restrictive. As a more tenuous alternative, family members may visit Canada over a period of ten years on the new "Family Super Visa", but are not eligible for any government-funded programs or services or for permanent residency (Bragg 2013, 17). Finally, to sponsor a spouse, couples who have been married for less than two years and have no children must be able to prove that they have been living together in Canada for at least two years (Bragg 2013, 17). This change was justified as a means of preventing marriage fraud, but has been criticized for increasing the risk of spousal abuse by pressuring couples to co-habit in order to get permanent residency (CCR n.d.).

Changes relevant to temporary foreign workers (TFWs) and refugees also stirred much debate. Between 2008 and 2015, for the first time in Canadian history, there were more people entering Canada

as TFWs, than as im/migrants or refugees with permanent residence (Bragg 2013, 9 and Alboim and Cohl 2013, 45). Notably, about 40 percent of TFWs are considered low-skilled¹⁵; and this subgroup grew especially quickly over that period. Since low-skilled TFWs generally do not have access to settlement services, permanent residency or family sponsorship, and are tied to a particular employer through their work permits, this shift allowed the government to fill significant workforce gaps with minimal investment (Bragg 2013, 9). But Canadian companies and workers have complained that the expansion of the TFWP encourages employers to favour foreign workers, and thus fuels xenophobic reactions. For example, a McDonald's franchise in Victoria, British Columbia came under investigation in 2014 for possible abuses of the TFWP after employees complained that Canadians got fewer shifts than foreigners, and that Filipino workers (who were not yet in the country) were being hired over university-educated locals (Tomlinson 2014). Similar complaints were later put forth by employees of large companies, including Siemens AG, Accenture Canada and Shaw Cable systems (D'Aliesio and Curry 2014 and Tarman 2014). More broadly, im/migrant rights advocates have argued that an emphasis on low-skilled temporary im/migration not only deviates from Canada's long-standing im/migration model, but also creates a 'disposable' workforce of migrant workers, and places an increasing number of people in precarious work environments and uncertain im/migration situations (see for example, Migrant Workers Alliance for Change 2016, CCR 2014b, and Valiani 2013, 55). In response to these critiques, in June of 2014, the government overhauled the TFWP (Employment and Social Development Canada 2015). These changes were aimed at "Putting Canadians First" – namely by preventing employers from abusing the program – but they did not add protections for migrant workers themselves (CCR 2014b).

¹⁵Low-skilled TFWs are legally defined as those able to fill occupations which require little or no formal education (Bragg 2013, 8). They may enter Canada through: the Live-in Caregiver Program, the Seasonal Agricultural Worker Program or the "Pilot Project for Occupations Requiring Lower Levels of Formal Training". Skilled TFWs are those who have at least two years of post-secondary education. They generally have better access to settlement services, permanent residency or family sponsorship (CCR 2014b).

In addition, the *Protecting Canada's Immigration System Act* (or Bill C-31¹⁶), incorporated into the IRPA in December of 2012, changed refugee protection. The bill was introduced in order to improve efficiency and fairness in the refugee determination process. Shortly after, Jason Kenney (Minister of Citizenship, Immigration, and Multiculturalism from 2008 to 2013) explained that Canada's "generous asylum system has been abused by too many people making bogus refugee claims" (Government of Canada 2012b). The reforms to the asylum system, he noted, would serve to fix a "broken" im/migration system and to send an important message: "if you do not need Canada's protection...you will not be allowed to remain in Canada for years using endless appeals at the expense of Canadian taxpayers" (Government of Canada 2012b). The bill introduced shorter timelines for processing refugee application, as well as a tiered refugee determination system¹⁷ (CCR 2014a). It also reduced access to health care for certain categories of refugees and refugee claimants through cuts to the Interim Federal Health Plan (IFHP). In response, many im/migrant and refugee advocate organizations, including the Canadian Council for Refugees, the Canadian Civil Liberties Association, Amnesty International, and the Canadian Association for Refugee Lawyers, publicly denounced the changes (CCR 2012). They argued that reducing application and processing timelines can create greater stress for refugee claimants because it gives them less time to gather appropriate documentation and prepare for a hearing in already quite stressful situations (CCR 2014a). They also noted that distinguishing between Designated Countries of Origin (DCO)¹⁸ and non-DCO applicants contributes to generalization within the refugee determination process, obscuring or ignoring the particular circumstances of each applicant, such as age, geographic location, sexual orientation or ethnic background (Molnar Diop 2014, 73). Perhaps most importantly, cuts

¹⁶Bill C-31 is also known as: An Act to Amend to Immigration and Refugee Protection Act, the Balanced Refugee Reform Act, the Marine Transportation Security Act, and the Department of Citizenship and Immigration Act (Parliament of Canada 2012).

¹⁷The reformed system separates refugee claimants from designated "safe" countries (designated countries of origin, or DCOs) from those that come from non-DCO countries.

¹⁸DCOs are defined by Citizenship and Immigration Canada (CIC) as "countries that do not normally produce refugees, but do respect human rights and offer state protection" (CIC 2016c).

to the IFHP were called “cruel and unusual punishment” and judged to be inconsistent with the Canadian Charter of Rights and Freedoms by the Federal Court of Canada (*Cdn Doctors v. AGC 2014 FC 651*)¹⁹. Chris Alexander, Immigration Minister from 2013 to 2015, responded to the Federal Court’s ruling by asserting that the government “vigorously defends the interests of taxpayers” and seeks to protect “genuine refugees” (Payton 2014). Combined with rising numbers of ‘irregular’ im/migrants in Europe and the US, and in line with global political trends, Bill C-31 contributed to a climate of criminalization and securitization around im/migration in Canada from 2012 to 2015 (Li 2003, 7, Alboim and Cohl 2012, 30-40 and Abu-Laban 2015, 3).

Also reflecting a post-9/11 securitization trend was the *Strengthening Canadian Citizenship Act* (Bill C-24), which became law in June of 2014 (Abu-Laban 2015, 3). According to Minister Alexander, this piece of legislation aimed to “protect and strengthen the great value of Canadian citizenship and to remind Canadians that citizenship is not a right, it’s a privilege” (Government of Canada 2014). As such, it made Canadian citizenship harder to get and easier to lose. Under this bill, permanent residents had to wait four years (instead of three, as in the past) before being eligible to apply for citizenship (Abu-Laban 2015, 4). In addition, application fees and benchmark language requirements increased and the citizenship test became more challenging than in the past (Bragg 2013, 26 and Abu-Laban 2015, 3-4). Evidence suggests that the fees were a burden for some im/migrants and that changes to the citizenship test are lead to increasing failure rates, especially for those not from English-speaking countries (Beeby 2010, Bragg 2013, 26 and Abu-Laban 2015, 4). At the same time, naturalized Canadians and dual citizens could lose citizenship on various grounds, including terrorism, treason, spying offenses and/or association with organizations known to have engaged in armed conflict with Canada (Abu-Laban 2015, 4). This last

¹⁹The Harper Government appealed this ruling to the Federal Court of Appeal but the Trudeau Liberals dropped the appeal once in office. While the Federal Court’s finding was a positive development for those that opposed the health-care cuts, both the Federal Court’s ruling and the Harper Government’s appeal created uncertainty around what types of coverage were and should be available for refugees and refugee claimants. This was until the Trudeau Liberals reinstated the full Interim Federal Health Plan (IFHP) for all refugees and refugee claimants in April of 2016 (CBC News 2016).

component of Bill C-24 was particularly worrisome to some because it prioritizes loyalty to Canada; and in combination with longstanding fears of foreigners, and post-9/11 securitization trends, could disproportionately and unfairly target Canadians of Arab and/or Muslim backgrounds (Payton 2014, Thompson 2014 and Abu-Laban 2015, 4).

Overall, key policy changes during the Harper era included a focus on temporary versus permanent im/migration, an emphasis on economic priorities over improvements to family reunification programs and refugee protection, greater barriers to obtaining and keeping im/migration status and citizenship, and a more restrictive refugee determination system (CCR 2014a). These changes and the policy strategies they are founded on are important, not only because they have practical implications for immigrants and refugees in Canada, but also because until recently, they helped to legally define who is more or less ‘valuable’ to the Canadian state. In October of 2015 however, a Liberal majority government led by Justin Trudeau was elected. Within their platform, they promised improvements to family reunification processes, easier access to citizenship for international students and restoration of the Interim Federal Health Plan (IFHP) for refugees and asylum seekers (Liberal Party of Canada 2015). Within Trudeau’s first four months in office, the latter of these changes was carried out, and 25,000 refugees were received in response to crises in parts of the Middle East and Europe (CBC News 2016). These changes must be recognized as significant improvements over the immigration and refugee policy of the Harper era. Moreover, Trudeau’s election and the first few policy changes his Government carried out sparked a wave of optimism, felt across Canada and around the world (EuroNews 2015 and Solomon 2016). But the focus on economic opportunity shouldered by immigrants remains (Liberal Party of Canada 2015). Though with a generally more compassionate approach than the Harper Government’s, the Trudeau Liberals’ “New Plan for Immigration and Economic Opportunity” is “largely driven by attracting talented people from around the world”, who will be able to build a life for themselves in Canada but who will also “contribute to the economic success of all Canadians” (Liberal Party of Canada 2015).

Public discourse on im/migration and multiculturalism

Bureaucratic categories help to define the legal criteria for admitting newcomers and to delineate the official borders of the nation, but they do not necessarily translate into “logically constituted social groupings” that reflect the actual experiences of im/migrants (Li 2003, 43). In practice, social definitions of ‘desirable’ and ‘deserving’ im/migrants mix and mingle with official ones, influencing Canadians’ perceptions of newcomers and newcomers’ perceptions of themselves (Li 2003, 43).

Statistics show that Canadian public opinion on immigration and multiculturalism is generally favourable, and exceptionally so in comparison to public opinions in other industrial countries (Reitz 2014, 99). Polls conducted by Gallup Canada between 1975 and 2005 show that every year except for 1982, majorities endorsed increasing im/migration levels or keeping them the same (Reitz 2014, 100). Similar results were obtained by EKOS Research Associates between 2004 and 2010: in 2004, the proportion of people who agreed with current or higher levels of im/migration was 63 percent versus 31 percent who thought there were too many im/migrants. In 2010, this ratio was 67 to 23 (Reitz 2014, 100).

Specifically, public opinion seems to align with and reflect utilitarian and humanitarian ideals embedded in im/migration policy. A 2010 nation-wide public opinion survey²⁰ found that clear majorities were convinced of the positive economic benefits of im/migration overall, even among unemployed Canadians, and in Ontario and British Columbia, where labour demand is generally high and im/migrants are numerous (Environics Institute 2010 and Reitz 2014, 102). The 2015 Focus Canada found that these attitudes have remained steady or grown more positive in the last three to five years, despite increasingly restrictive im/migration and citizenship policy (Environics Institute 2015). Moreover, multiculturalism

²⁰The Focus Canada public opinion research program was first launched in 2010 to “take the pulse of Canadians on a wide range of public policy and social issues” (Environics Institute 2010). A new survey is developed and conducted every year, most recently, around specific topics like climate change in 2014 and im/migration and multiculturalism in 2015 (Environics Institute 2015).

has generally been considered one of the Canada's most important principles for almost four decades, and this view has strengthened since 2010.

There seem to be, however, widespread questions and concerns about multiculturalism in practice. In 2010, a majority of nearly 70 percent were concerned about the fact that there are “too many immigrants coming into [Canada] who are not adopting Canadian values” (Reitz 2014, 102). Moreover, in the 2010 Focus Canada survey, about 80 percent of respondents agreed that immigrants should blend into Canadian society and not form separate communities (Enviroics Institute 2010 and Reitz 2014, 102). In 2015, Focus Canada claimed, this was “the most significant ongoing public concern” (Enviroics Institute 2015). In particular, there were concerns about “ethnic groups”, most notably, Muslims (Enviroics Institute 2010, Li 2003, 171-172 and Reitz 2014, 102-103). In 2010, a majority of Focus Canada respondents reported that they believed that Muslims wanted “to remain distinct rather than adopt mainstream Canadian customs”, and there was a growing proportion of people who endorsed a ban on Muslim scarves in public (Enviroics Institute 2010, and Reitz 2014, 102-103). In 2015, this trend diminished only slightly, but there seemed to be a growing awareness of ongoing discrimination against those considered minority groups, including Muslims, Aboriginal peoples, Blacks and South Asians (Enviroics Institute 2015).

Some suggest that beyond official polls and surveys such views tend to be rationalized using subtly racialized discourses (see for example Bissoondath 1994, Abu-Laban 2002, Mackey 2003, Li 2003 and Thobani 2007). In particular, Mackey (2003) and Li (2003) find that those who are unwelcoming towards ‘ethnic groups’ tend to justify their views based on the premise that such groups “represent unbridgeable differences that [could] undermine the social landscape, the normative order, and the European tradition of Canada” (Li 2003, 171). Some often cited differences include: immigrants’ tendency to congregate in particular neighbourhoods and to disregard Canadian heritage, traditional values, architectural preservation and environmental protection, as well as the undue demands placed by im/migrant families on the Canadian school system, as a result of their children not speaking (or wanting

to speak) the official languages (Li 1994 and Li 2003, 130). But these challenges tend to be described as “problems of diversity” or “the cost of difference” to Canadians “who support humanitarian and tolerant traditions [...] but who nevertheless worry about Canada losing its national identity” (Mackey 2003, 160 and Li 2003, 132). Terms such as *diversity* and *difference* help to neutralize and conceal judgments based on race, while the logic of ‘tolerance’ and ‘culture/identity crisis’ serve to legitimize them (Mackey 2003, 152 and Li 2003, 130). Li (2003) further suggests, opinion polls legitimize racism by using this type of discourse and by giving Canadians a public, ‘acceptable’ forum where they can evaluate im/migrants based on superficial features. For instance, in 2000 a survey conducted by Ekos Research Associates asked respondents: “of those who come [to Canada], would you say there are too many, too few or the right amount who are members of *visible minorities*?” (Li 2003, 172). Past polls have also used phrases like “people who are different from most Canadians”; and more recently, “ethnic groups” to allude to non-white people while avoiding explicitly racist terms (Li 2003, 172 and Environics Institute 2010). In turn, the sometimes unfavourable results of such polls may be treated by media and government as an indication of public backlash – and therefore, justification for policy direction – rather than as an issue of racism and discrimination (Li 2003, 174). Mackey (2003) adds that frequent descriptions of Canada’s commitment to multiculturalism as superior to the US’ ‘melting pot’ approach, further validate Canadians’ idea of ‘tolerance’, and obscure racist undertones in im/migration discourse. References to the Canadian “mosaic”, its “colours” and “flavours”, she notes, also romanticize Canadian multiculturalism and conceal the challenges of im/migration for newcomers as well as receiving communities. Notably, however, Reitz and Breton (1994) found that in general, Canada and the US incorporate newcomers into society similarly in similar ways.

While the opinions and discourses described in this section are mainly of those who consider themselves Canadians, they are significant, not only because they influence im/migration policy, but also because they constitute the socio-cultural context in which newcomers’ conceptions of deservingness emerge. As evidenced by public opinion polls and surveys, Canadians generally support and take pride in

Canada's commitments to im/migration and multiculturalism. When it comes to describing the practical realities of multiculturalism, however, public discourse seems to reveal discriminatory tendencies with respect to how im/migrants and im/migration are assessed and valued in Canadian society. These assessments and evaluations are likely to impact how im/migrants see themselves, their roles, and their deservingness in their host communities.

From global to local: Northern Ontario as field of research

Home to Canada's capital and some of its largest cities, the province of Ontario has a particularly long history of international im/migration and settlement (Wiseman 2007). It receives more than 110,000 im/migrants – the bulk of im/migration to Canada – every year (Tolley et al. 2012, 2 and Statistics Canada 2015). The majority of newcomers settle in the Greater Toronto Area (GTA), but communities of various sizes seem to be becoming increasingly attractive settlement options (Tolley et al. 2012, 2-3). About 96 percent of im/migrants are now settling in 12 urban centres: Toronto, Hamilton, Windsor, Kitchener, Ottawa, Guelph, London, St. Catharines-Niagara, Kingston, Thunder Bay, Peterborough and Sudbury. This “regionalization” of im/migration is evident across the country, but especially in the Prairies and in Ontario (Tolley et al. 2012, 2). In these provinces in particular, small communities are experiencing population decline and economic stagnation, and are thus eager to attract and retain newcomers (Tolley et al. 2012, 2 and National Working Group on Small Centre Strategies, 7).

In Ontario, the regionalization of im/migration has also been facilitated by the growing role of municipalities in newcomer settlement. This shift began in the mid-1990s, when a Conservative provincial government led by Premier Mike Harris embarked on a Local Service Realignment program that aimed to reallocate responsibility for a number of social services to the municipal level (Tolley et al. 2012, 3). As part of this process, the province also replaced the Ontario Settlement and Integration Program (including the Ontario Anti-Racism Secretariat, Newcomer Language Orientation classes, and

the Multilingual Access to Social Assistance Program) with the Newcomer Settlement Program, and slashed funding related to settlement, integration and inclusion services in half. Although this placed significant financial responsibilities on Ontario municipalities, some argue it also created more room for local initiative and change, particularly with respect to health care and social services. Moreover, municipal involvement in im/migration and settlement “shifted discourse toward place-based policy-making, and multilevel governance and partnerships”, which became the cornerstones of the present im/migration and settlement scheme, the Canada-Ontario Immigration Agreement (COIA) (Tolley et al. 2012, 3).

The COIA was signed in 2005. Through this agreement, the Federal Government committed \$920 million to supporting the delivery of settlement services and language training for newcomers in Ontario communities (Government of Canada 2013). It aims to: improve social and economic outcomes for newcomers, build partnerships with municipalities and engage them in areas of im/migration related to their interests, and increase the economic benefits of im/migration (Ontario Ministry of Citizenship, Immigration and International Trade 2015). One of the most important achievements of this agreement thus far has been the development of Local Immigration Partnerships (LIPs). LIPs are municipal or regional coalitions designed to strengthen local awareness and capacity to attract and integrate im/migrants, plan and coordinate delivery of settlement programs and services, and improve im/migrants’ access to the labour market (Tolley et al. 2012, 8 and Pathways to Prosperity: Canada 2016). They operate mainly through partnership councils “charged with developing and implementing strategies to produce more welcoming communities” (Pathways to Prosperity: Canada 2016). These partnerships include settlement service providers, municipalities, federal and provincial agencies, employer associations, health organizations, ethno-cultural and religious groups, school boards, academic institutions, etc. The LIPs have also been coupled with the Welcoming Communities Initiative (WCI), a multidisciplinary alliance of universities, colleges and community organizations dedicated to researching best practices in im/migration and settlement across Ontario. The LIP initiative has been found to be

successful across Ontario and has now been expanded to other provinces (Pathways to Prosperity: Canada 2016).

LIPs are especially important for the growth and development of Northern Ontario communities. While political and economic stakeholders in these communities recognize the importance of meeting the needs of newcomers, they prioritize attracting im/migrants in order to slow economic decline (Southcott 2012, 316). The recent development and impact of the LIPs in the two largest Northern Ontario cities, the City of Greater Sudbury (also known as Sudbury) and Thunder Bay, have been relatively well documented. Since 2011, in Sudbury, the LIP has helped to establish a more cohesive and tailored immigration and settlement plan of action among all of the local organizations whose services affect immigrants or are affected by them (Nangia 2012, 268 and Sudbury Immigration Services 2011, 7). Thanks to this effort, as well as to the municipality's commitment to attracting more immigrants, the increasing diversification of the economy and the emergence of the region as a centre of commerce, health, education, science and technology research, im/migration and diversity are growing in the city (Nangia 2012, 273 and Sudbury Immigration Services 2011). In practice, however, progress on im/migration and settlement service integration is slow and newcomers are still relying on generic organizations and programs, like the Sudbury Multicultural and Folk Arts Association (SMFAA), the Contact Interculturel Francophone de Sudbury (CIFS), community health centres, legal clinics, the local university and college, etc. (Nangia 2012, 271). Since 2007, in Thunder Bay, attracting im/migrants and Aboriginal Canadians to the city has also been increasingly considered a priority by community leaders. But community members, who for the last 40 years have not been used to welcoming many newcomers, have shown some apathy towards issues of im/migration and settlement (Southcott 2012, 316). In addition, since 2004, the Thunder Bay Multicultural Association has acted as a "one-stop-shop" for im/migration and settlement services (Southcott 2012, 313 and Thunder Bay Multicultural Association 2016). As a result, the focus of the Thunder Bay LIP is less on service coordination and more on "awareness, integration and nation-building" (Thunder Bay Multicultural Association 2016). Thanks to

this effort, there is some evidence of a change in attitude and tolerance among Thunder Bay residents (Southcott 2012, 317).

Likely because of its smaller size, Sault Ste. Marie has received less attention as an im/migration and settlement hub. Not only is this Northern Ontario area mostly uncharted in this respect, but it is also quite distinct – geographically, demographically, socio-culturally and economically – from Canadian cities that receive the majority of newcomers, and where im/migration and settlement issues have typically been studied. Still, it is a location that has seen a significant increase in immigration in the last decade. Sault Ste. Marie was selected as a research location in order to generate new insight into im/migrants’ experiences of deservingness in a very particular im/migration context, and to expand this type of research beyond the more commonly studied large urban research sites. In turn, this study may be considered a stepping stone in a broader investigation of how im/migrants’ deservingness is locally reckoned and negotiated across a variety of im/migration contexts; and how local and global linkages affect these processes.

Conclusion

This chapter provides a broad-scope review of the historical, political, economic and socio-cultural context in which im/migrants’ conceptions of deservingness emerge. Although my focus is primarily on immigration and settlement in Canada, the scope of the chapter necessarily includes global to local links to highlight the far-reaching implications of my research. I have taken a historical/chronological approach in my research and writing, in order to emphasize the deep roots of present-day policy, debates and public discourse on the role and merits of im/migrants in Canada.

At the broadest level, due to Canada’s relatively advantageous position in global “flows” and to its prestige as one of the most generous countries in the world, local assessments of im/migrants’ merits here often hinge on humanitarian and utilitarian criteria. For instance, how can im/migrants contribute to

economic growth and/or how might they help to sustain Canada's global identity as a multicultural, benevolent nation? Such humanitarian and utilitarian criteria are certainly evident in current im/migration policy and politics. Policy seems to be increasingly focused on facilitating im/migration for those who possess professional expertise, highly specialized skills and financial capital, while those who are marginalized and displaced and who generally lack these assets are increasingly admitted only on a temporary basis. Now, perhaps more than ever, there is a focus on temporary versus permanent im/migration, an emphasis on economic priorities over improvements to family reunification programs and refugee protection, greater barriers to obtaining and keeping im/migration status and citizenship, and a more restrictive refugee determination system (CCR 2014a). These changes help to define resource-rich im/migrants as the most 'valuable', and therefore most deserving to the state. Humanitarian and utilitarian criteria seem to also underlie public opinion, as evidenced by the misalignment between widespread support for multiculturalism and subtly racialized public discourse on im/migrants. These criteria, of course, did not emerge in vacuum. They are rooted in the long-standing economic role of im/migrants as settlers, workers and consumers, but also in their social role as "'others' who reflect back Canada's white self-image" (Mackey 2005, 15). It is crucial to highlight that humanitarian and utilitarian criteria are not necessarily used by im/migrants themselves. In fact, there is very little literature on how im/migrants understand their own merits (in Canada or elsewhere). However, as a key part of the historical, political, economic and socio-cultural context, humanitarian and utilitarian criteria are likely to be an important influence on im/migrants' conceptions of deservingness. This study is a step towards understanding *if* and *how* those types of criteria and the related historical, political, economic and socio-cultural context impact im/migrants' conceptions of deservingness.

CHAPTER 3: Fieldsite and Methodology

Studying health-related deservingness in Sault Ste. Marie, Ontario

Though my choice to conduct fieldwork in Northern Ontario may appear out of the ordinary, my rationale for doing so is manifold. As mentioned earlier, the region in and around Sault Ste. Marie remains relatively under-investigated as an im/migration and settlement hub, despite its unique features as a host community, its growing population of im/migrants and its focus on and need for a sustainable im/migration and settlement strategy. Most importantly, however, I chose to conduct my fieldwork in this region based on my own (and my family's) experience after im/migrating to Sault Ste. Marie from Argentina approximately 14 years ago. At the time, there were few to no im/migration and settlement services in the area and the community of recent (non-European or non-Anglophone) im/migrants was very small. We faced many challenges in adapting to this relatively isolated, small and socio-culturally homogenous region, but some of our greatest difficulties were in developing identities that not only we, but also those around us, could consider 'valuable' in this new context. This identity-building process was most difficult for my mother, who had been a highly-trained visual arts professor in our home country, but whose qualifications and English language level were, for many years, not recognized as 'good enough' to teach at the local university or college. Moreover, as a relatively reserved stay-at-home mother, it was very difficult for her to establish new roots and networks in the community that could support her – physically, mentally, and emotionally – through the transition. My father, on the other hand, was widely recognized and highly valued for his work as an engineer in the local steel industry which brought economic growth and prosperity to the region. As a high school student and witness to my parents' hardships throughout that time, my experience of these challenges was perhaps less direct or acute, but no less impactful. The work of Fassin (2012), Willen (2012a) and (2012b), Larchanché (2012) and Ticktin (2013), on the little-known moral dimensions of im/migration and their impact on health and well-being, resonated with this experience and inspired me to explore similar ideas in the place I consider my hometown. In general terms, then, I set out to investigate whether or not other im/migrants in the

Sault Ste. Marie area have similar experiences around identity, self-perception, self-worth and deservingness to those of my family, and how this affects their overall health and well-being.

Conscious of my own biases in designing an investigation based on my own experience and in my home community, I planned series of pre-fieldwork visits to consult with *New to the Sault* staff and potentially also with newcomers throughout the community, about my methods, instruments and the appropriateness of my work from their perspectives. My fieldwork plan combined traditional anthropological and ethnographic methodologies, namely participant observation, in-depth, semi-structured interviews with key informants, and focus groups.

Overview of fieldsite: Im/migration and settlement in Sault Ste. Marie, Ontario

With a population of 75,141, Sault Ste. Marie is the third largest city in Northern Ontario (Tourism Sault Ste. Marie n.d.). It is also the largest community between Sudbury and Thunder Bay, located in Northeastern Ontario, or the Algoma District. To the East, the city is bordered by the Rankin and Garden River First Nations. To the South, it is bordered by its twin US city, Sault Ste. Marie, Michigan. The two cities are separated by an international bridge and by the St. Mary's River, which connects the Great Lakes. They share the St. Mary's rapids, which makes both communities long-established prime locations for commerce, transportation, industrial development and settlement. As such, the area has a long history of im/migration (Sault Ste. Marie Local Immigration Partnership [LIP] 2013, 2-3). As early as the 1600s, French, English, First Nations and Métis groups conglomerated around a fur trading post established there (Sault Community Career Centre [SCCC] 2016a). But the city's greatest growth and development occurred in the late 1800s and early to mid 1900s with the arrival of American and Italian im/migrants, who established successful steel and forestry industries (City of Sault Ste. Marie 2015 and SCCC 2016b). Nordic, Polish, Ukranian, and Croatian im/migrants followed, making

significant contributions to the growing manufacturing industries, and to agriculture in the area (SCCC 2016c).

More recently, im/migrants settling in Sault Ste. Marie have been less commonly from Europe, and increasingly from the US, Latin America, Asia and the Middle East (Sault Ste. Marie LIP 2013, 3). Much like in Sudbury and Thunder Bay, however, Sault Ste. Marie stakeholders only began to focus on this shift about a decade or so ago. In 2008, a report produced by the City's Engineering and Planning Department on Population and Housing presented some of the key challenges for the community in the upcoming decades. The report highlighted an aging population, a dwindling labour pool and economic stagnation (Sault Ste. Marie LIP 2013, 85). The report projected that deaths of local citizens will increasingly outnumber births, and that those leaving the workforce will quickly outnumber those entering it. Many of those leaving the workforce or who expect to do so in the near future are baby boomers, who now range in ages from 47 to 66 and make up roughly 31% of Sault Ste. Marie's population (Statistics Canada 2011 and Sault Ste. Marie LIP 2013, 86). The report also specifically advised that a significant number of foreign workers will be required to maintain the existing labour force (Sault Ste. Marie LIP 2013, 90-91). An increase of approximately 3,000 workers was projected to be required between 2011 and 2016, 6,000 between 2016 and 2021, and 8,000 between 2021 and 2026. Roughly double these numbers are required in order to grow the labour force by 0.5 percent over the same time period.

With these projections in mind, city leaders immediately focused on initiatives to attract and retain im/migrants (Sault Ste. Marie LIP 2013, 2). With funding from the Canada-Ontario Immigration Agreement (COIA), they developed and launched an Immigration Web Portal, www.discoverthesault.ca. In 2009, the City became the lead organization of the LIP, which began as a group of 40 members representing 30 local organizations from all sectors, as well as im/migrants (Sault Ste. Marie LIP 2013, 2). After a series of research, planning and preliminary action phases between 2009 and 2013, the LIP

arrived at an im/migration and settlement strategy titled “Creating a Welcoming Community”, which got underway in 2015.

The Sault Ste. Marie LIP has grown to include over 50 members, a LIP council, and 4 sub-committees devoted to the common goal of “creating a welcoming community for all immigrants to Sault Ste. Marie” (Sault Ste. Marie LIP 2013, 3). The LIP council provides leadership and recommendations on programs, distribution of information and action on further research, while the sub-committees (focusing specifically on education, employment, health care and cultural awareness) design and implement programming (Sault Ste. Marie LIP 2013, 3-4). Some of the LIP’s main achievements include: various community awareness campaigns (e.g. annual im/migration forums, two world flag raising ceremonies and more than ten cultural events and festivals), cultural sensitivity training programs in more than five major community organizations (e.g. the City of Sault Ste. Marie, the Algoma District School Board, the Group Health Centre, Sault College, and the Great Lakes Forestry Centre) and an extensive Immigration Web Portal Video Library that provides “cultural orientation” to newcomers (Sault Ste. Marie LIP 2013, 26-39) .

As a key part of the LIP, *New to the Sault* is Sault Ste. Marie’s “one-stop service” program for newcomers to Canada, who are permanent residents, live-in caregivers or convention refugees (Sault Ste. Marie LIP 2013, 44). The program is offered through the Sault Community Career Centre (SCCC) a not-for-profit resource centre. It was developed beginning in 2006, in response to an increasing need for im/migration and settlement services in the community. Originally, *New to the Sault* provided only three main services, but with additional funding from Citizenship and Immigration Canada (CIC), it has expanded significantly since it was introduced. The program has three main objectives: 1) to provide orientation, needs assessment, relevant information and referral services to newcomers in Sault Ste. Marie and area; 2) to provide employment related services to support integration of newcomers into the community; and 3) to provide access to language assessment tools, to refer newcomers to language training services, and to support professional and cultural mentoring opportunities (Sault Ste. Marie LIP

2013, 44). *New to the Sault* serves all communities in the Algoma District, from Sault Ste. Marie to Blind River. Services include: newcomer orientation activities (e.g. needs assessments, information and practical guidance, a newcomer mentorship program, etc.), language skills training and cross-cultural workshops, translation and interpretation, career and employment assistance, social activities and festivals, assistance with im/migration documentation and processes as well as counseling. Notably, *New to the Sault* also provides its services in seven different languages and hosts the largest multicultural event – called *Passport to Unity* – in Northern Ontario. The program’s activities and services are developed and delivered by a team of five settlement counselors and resource specialists in a local space within the SCCC; or in community spaces, such as community gardens, parks, kitchens, etc. (SCCC 2016d). Newcomers can freely attend activities and events open to the community or they may choose to be matched with a settlement counselor to access *New to the Sault*’s specialized services. In addition, the program partners with a number of other community groups that work under the LIP umbrella: the African Caribbean Canadian Association of Northern Ontario, the Algoma Latin Association, Algoma Public Health, the Group Health Centre, the Local Health Integration Network (LIHN), the Algoma District School Board, the Algoma Multicultural Centre, the City of Sault Ste. Marie, Algoma University and Sault College, among others (Sault Ste. Marie LIP 2013, 52-67).

Thanks in part to the developments brought about by the LIP and *New to the Sault* since 2006, Sault Ste. Marie has successfully welcomed many new foreign owned businesses, trained professionals and post-secondary students (Sault Ste. Marie LIP 2013, 2). In fact, the number of im/migrants who reported Sault Ste. Marie as their place of destination has more than doubled over this time. The primary pull factors are opportunities for employment in the steel, forestry and energy industries, and opportunities for advanced education and training at the local university or college. The number of international students enrolling in the two post-secondary institutions is increasing, with numbers more than tripling each year. Roughly 400 im/migrants arrived in Sault Ste. Marie between 2005 and 2010,

from more than 60 different countries. Most are from the US (26%), Argentina (14%), China (8%) and India (7%).

Preliminary fieldwork and relationship-building

As a result of my parents' involvement with the growing community of newcomers in Sault Ste. Marie, I had various acquaintances relevant to my study prior to planning it. Between January and February of 2014, while drafting a research proposal, I contacted some of these acquaintances via e-mail to explain the work I planned to do, and to collect feedback on potential partner organizations. (I anticipated that *New to the Sault* would be most appropriate but looked to confirm this with community members.)

On advice from three different acquaintances, I connected with *New to the Sault*. As a “gateway” into the community for newcomers to Sault Ste. Marie, the program had the potential to share with me a wealth of knowledge about and connections with im/migrants in the community. Moreover, I noted that the program is conducted in a very accessible community location, equipped with private offices and public spaces, and therefore appropriate for conducting informant interviews as well as participant observation. *New to the Sault* is also well-connected with key health-related organizations in the community, such as Algoma Public Health, the Group Health Centre and the Local Health Integration Network (LHIN), which im/migrants are likely to access for health care, and which could therefore be additional sources of information and/or study participants.

In February of 2014, I sought out the *New to the Sault* program coordinator and met with her to discuss a potential role for the program in my research. She demonstrated interest in my research idea. We agreed that *New to the Sault* could assist me in recruiting potential participants and provide access to the program's various activities (e.g. ESL classes, workshops, and group activities in the community), where I could conduct participant observation. I was also invited to the Sault Ste. Marie LIPs fourth

annual “Racial Harmony” Immigration Forum later that month, where I would be introduced to other *New to the Sault* staff and partners and to the state of im/migration and settlement in Sault Ste. Marie.

At the Forum, I met *New to the Sault*'s Executive Director, two main settlement counselors and resource specialist, as well as a CIC liaison and various LIP representatives, including those from the City of Sault Ste. Marie, Algoma Public Health, the Algoma District School Board, Algoma University, Sault College, the Northland Adult Learning Centre, the Algoma Latin Association and the Algoma Multicultural Association. I also gathered a variety of local historical, economic, demographic and socio-cultural information related to im/migration and settlement in the region. Most importantly, however, I collected notes on a series of presentations made by newcomers about their experiences re-building their lives in Sault Ste. Marie. A few of them shared stories of how they had developed feelings of self-confidence and self-worth around work and family, and emphasized how important these processes had been to building their identities and a sense of belonging. This all seemed to align with the literature on im/migration and deservingness that I had been exploring, and with my family's experience, further encouraging me to develop my research questions around this topic.

Participant recruitment and data collection

Since I was already familiar with the Sault Ste. Marie community, when I arrived there in late June, 2014, my first step was to meet with the *New to the Sault* coordinator and settlement counselors to review my research questions and instruments and to devise a participant recruitment strategy. Based on their knowledge of the newcomer community and on some of their own experiences as newcomers, they advised that the concept of “health-related deservingness” (Willen 2012a and 2012b) that I had focused on in my research questions could be a bit narrow for the context. They suggested taking a broader look at how feelings of self-worth and deservingness form, and how they impact newcomers' identities, feelings of belonging, and overall health and well-being in the host community. This did not greatly change my

research instruments, but provided a slightly broader scope for the semi-structured interviews and focus groups I had planned. With regards to recruitment, I was advised not to contact *New to the Sault* clients directly for privacy and confidentiality reasons. Instead, the *New to the Sault* staff agreed to send out my study information and invitation to participate to individuals on their client database who they thought might be interested. Those who expressed interest would be put in touch with me. As another initial step, I toured the Sault Community Career Centre (SCCC) facilities, met other staff in the Centre, and signed up to participate in various *New to the Sault* activities, in order to become better acquainted with the program and with its clients. Finally, in exchange for the staff's help and support, I agreed to share my findings at the SCCC and to participate in, and support *New to the Sault's* English Conversation Circles (weekly ESL practice sessions), where possible.

Potential participants were chosen using a combination of convenience and purpose sampling. Considering 1) the relatively small size of the immigrant community in Sault Ste. Marie, 2) the small range of pull factors that attract immigrants to the region, and 3) the broad scope of my research topic and questions, I aimed to recruit a heterogeneous group of participants in terms ethnic and socio-cultural background. I only required that potential participants be adults (over 18 years of age), users or past users of one or more of *New to the Sault's* services, and intermediate level English-speakers (by informal standards). Following our initial meeting, the *New to the Sault* staff put in me in touch with six individuals who met these requirements, and who were available and interested in participating in my study. I then contacted each individual directly, via phone or e-mail, to explain the study in more detail, answer questions and schedule in-person meetings, provided the individuals were still interested. In addition, I announced my study during some of *New to the Sault's* public activities, including English Conversation Circle meetings, lunchtime get-togethers at the community garden, workshops, and cooking classes throughout July and August. Four additional participants expressed interest through these channels.

From mid-July until the first week of September (approximately six weeks), I conducted ten interviews with newcomers. At the participants' requests, eight of the interviews took place in the interviewees' homes. Although there were private spaces available to us for this purpose at the Sault Community Career Centre (SCCC), the eight participants chose to be interviewed at home for reasons of comfort and/or convenience. Five of these eight participants did not drive and preferred not to take a taxi or public transportation, as both are expensive and generally inconvenient in Sault Ste. Marie. (This was despite the offer of remuneration for any transportation expenses incurred.) The remaining three reported that they would feel more comfortable and undisturbed in the privacy of their own home. In all cases and at the participants' doing, there were no other individuals in the home at the time of the interview, and so we were able to talk comfortably, privately, and without disturbances. Two additional interviews were completed in locations outside of the SCCC – one over the phone, and one in the local university's library. With regards to the former interview, it is important to note that participant was a busy mother of a newborn. She had a tight schedule, and found it inconvenient to have to leave her home or to have the interview there, so we deemed a phone interview the best possible alternative. Finally, the last interviewee was a university student, so – he noted – the university environment was more convenient, familiar and comfortable to him. This interview took place in a private library study space. All interviews were recorded using a digital recording device. Taking into consideration potential language barriers, all participants were offered the option of having consent forms and interview questions translated into a language of choice and/or using one of *New to the Sault's* interpreters during their interview. However, no participants chose to do so.

The interviews were semi-structured and open-ended, to encourage a wide scope of perspectives (See Appendix A). They ranged in length from 30 minutes to one and half hours. In order to build rapport and make participants feel comfortable, each interview began with a series of general questions on what I called the 'im/migration journey' (e.g. when, why and how they arrived in Canada, their expectations and first impressions of the community, etc.). Next, I asked interviewees whether or not they felt they deserve

health care. I also inquired about self-perception and self-worth (see Appendices A and B), as reflective of broader conceptions and experiences of deservingness. I first asked a few questions to gain insight into: 1) how interviewees view themselves as immigrants and how they think others view them (i.e. self-image and identity), and 2) how they value themselves as community members and how they think others value them (i.e. self-worth and identity). I also asked how they saw those opinions impacting their lives, and how they responded to this. In the last and longest section of each interview, I focused on interviewees' conceptions of health, health care and health-related deservingness, and aimed to get a sense of the practical impact of individual and perceived moral judgments. I asked interviewees to compare and contrast health care experiences in Canada versus in their home countries, describe how their experiences may have been affected by others' judgments, and also describe and/or justify their deservingness of public health care vis-à-vis other community members, particularly non-newcomers. The semi-structured nature of the instrument allowed me to modify the pace, order, and complexity of the questions according to each individual conversation, to interviewees' level of English and understanding of the topics discussed, and to any feedback received throughout the fieldwork period.

I also conducted a single focus group intercalated with the interviews. The group was comprised of seven members not including myself. Four of the seven participants also participated in one-on-one interviews; three participants completed their interviews prior to the focus group and one individual did so in the weeks following the focus group. I had originally planned to complete two focus groups, one at the beginning of my fieldwork and one at the end. I had also planned to recruit focus group participants through *New to the Sault* as with the one-on-one interviews, and had aimed to speak to individuals different from those who participated in the interviews. Through the focus groups I had hoped to gain a broader understanding of the types of reasoning that underlie conceptions and experiences health-related deservingness (Bernard 2011, 173). I imagined that a group conversation could effectively elicit not just how individuals reason deservingness on their own, which I had hoped to glean from the interviews, but also how they justify it to and with others. My probing questions then, were more open-ended than but

quite similar to my interview questions (see Appendix B). I was more interested in the back-and-forth debates and dynamics that those questions could spark than on the details of participants' responses.

Since the recruitment process was relatively slow and there were few potential participants available, however, I decided early on in my fieldwork to hold only a single focus group close to the end of my time in Sault Ste. Marie. In addition, during one of the English Conversation Circle sessions I attended, the ESL instructor in charge chose to use my research as a topic of conversation and practice. Noticing that all group members were very enthusiastic about the topic, I announced early on in the session that I was hoping to conduct a similar group discussion at a later date as part of my research, and invited them all to contact me if they wished to participate. One of the group members then asked me if I could include his comments from that specific ESL session in my research, since he would likely not be around for the next discussion. Without input from me or the ESL instructor, the other six members of the group also expressed interest in doing the same, for matters of convenience. Keeping in mind ethics protocol, I judged that this would be acceptable as long as all group members were in agreement, and each completed a focus group consent document. So, after a short pause in the discussion to print off and complete consent forms, I began recording the group's comments and asking the probing questions I fortunately had with me. The focus group lasted approximately an hour and a half, and took place in one of *New to the Sault/Sault Community Career Centre (SCCC)*'s boardrooms.

The demographic characteristics of the study participants are listed in Table 1. Of a total of 12 participants the majority were females between 31 and 40 years old. The individuals represent a wide range of countries of origin, including Mexico, India, Japan, Indonesia, Germany, Spain, Pakistan and Argentina. They also represent a variety of occupations, including teachers, engineers, students, counselors, mothers and homemakers. None of the participants reported English to be their mother tongue, but all spoke and comprehended English at a medium to high level (by informal standards). Five individuals participated in both a one-on-one interview and the focus group (as indicated by an X in the

chart), another five individuals participated in an interview only and two other individuals took part in the focus group only.

Table 1. Demographic Characteristics of Study Participants

Participant Pseudonym	Age Range	Gender	Interview	Focus Group
1	31-40	F	X	X
2	61-70	F	X	X
3	61-70	M	X	X
4	31-40	M	X	X
5	31-40	F	X	
6	21-30	M	X	
7	41-50	F	X	X
8	31-40	F	X	
9	31-40	F	X	
10	51-60	F	X	
11	31-40	F		X
12	31-40	F		X

The data I collected through one-on-one interviews and the focus group is complemented by field notes from 40+ non-consecutive hours of participant observation completed throughout my fieldwork (approximately eight weeks total). I had originally planned to conduct participant observation in a combination of public, health-related settings, such as waiting spaces in the Service Ontario office (where health cards are obtained) and health care centres typically frequented by newcomers. However, during my initial discussions with *New to the Sault* staff, I was advised that since those types of locations do not serve only newcomers, it would be near impossible to distinguish relevant from irrelevant data as an observer. Instead, the staff suggested that I attend some of *New to the Sault's* public activities, including lunchtime get-togethers, weekly educational workshops and cooking classes. I attended the following

events and activities: semi-weekly lunches at the community garden or the *New to the Sault* space, five educational workshops of varying lengths (topics included: diabetes, mental health, intimate partner abuse, the process of applying for permanent residency and citizenship, as well as finances and real estate purchase in Canada), and two cooking classes. I also spent time in and around the *New to the Sault*/Sault Community Career Centre (SCCC) common space. In each of these settings, I focused on recording newcomers' perceptions, conceptions, expectations and opinions around health and well-being, health care, self-perception, self-worth, identity, belonging and deservingness. In turn, I also focused on what I understood to be some of the practical implications of these factors (e.g. interactions with non-newcomers on these topics, responses to conflicting perceptions, conceptions, expectations and opinions, etc.). The educational workshops where health-related topics were discussed were especially telling and useful. But I also came across many relevant conversations and interactions during the lunchtime gatherings and cooking classes since these activities were centered on food, health and overall well-being as well. In addition, the educational workshops related to citizenship, finances and housing provided insight into broader conceptions of deservingness, beyond health and health care.

Challenges and limitations of the study

One of the most significant challenges I faced during the course of my fieldwork was in logistics, namely participant recruitment. Knowing that the community of im/migrants in Sault Ste. Marie is quite small compared to im/migrant communities in major hubs like the Greater Toronto Area, Vancouver or Montreal, I had anticipated that recruitment would not be easy. I did not anticipate, however, that the majority of the newcomers in the region would be away on vacation or visiting family in their home countries over the summer months. This meant that tracking down and sending my study information to the even smaller subgroup of people who met the inclusion criteria was a very time-consuming process for the *New to the Sault* staff. In turn, from an ethics standpoint, I felt I needed to minimize the amount of time they had to invest in this process, as well as the pressure they felt to meet my requests. As a result, I

found myself allotting quite a bit of time towards managing our relationship, including reassuring them that even a small number of participants would be useful, and having friendly and informal discussions about alternative recruitment strategies or the possibility of returning to the field at a later date. Alternative recruitment options were very limited due to *New to the Sault's* privacy and confidentiality rules, which prohibited me from accessing any client information directly. As mentioned earlier, one option was to recruit participants directly by making announcements about my study at public *New to the Sault* activities, but this option was also limited, as the majority of these activities had relatively low turnout. Also a result of the slow recruitment process, I had to wait until week four of my fieldwork to begin holding interviews, and then struggle to schedule as many interviews as possible, as well as the focus group, closer to the end of my time in Sault Ste. Marie. I was unable to fit in a second, post-interview focus group at the end of my stay, or to complement my data with additional interviews from non-newcomer health care professionals, as I had planned to do. On the other hand, I expected language barriers to be much more of a challenge than they actually were. While I was prepared to get ethics documents and interview questions translated, and use *New to the Sault's* interpreter services where required, none of the study participants requested either of these options when they were offered prior to each interview. In fact, I found that all participants' level of English, as well as their understanding of topics like the Canadian health care system and im/migration politics were quite advanced and complex. Only one interviewee (P1), who knew that I am a native Spanish speaker, chose to respond in Spanish to my questions. She explained this was because she was happy to be able to have a conversation mostly in Spanish, and also because she felt like she could provide more detailed answers that way. She repeatedly noted however, that she had no problem comprehending the ethics documents or questions. This was evident in her responses.

I also encountered three main ethics concerns throughout my fieldwork. The first was the issue of holding one-on-one interviews at interviewees' homes rather than at the *New to the Sault/Sault* Community Career Centre (SCCC) space, as I had planned to do. When I was first asked by one of the

participants if doing an interview at home was an option, I was concerned that we may not be able to find a space in the individual's home that was neutral (i.e. open and comfortable) yet private (i.e. free of disruptions and/or opportunities for others to listen in). I agreed to this first request since the participant had repeatedly mentioned that it would be a significant inconvenience for her to attend the interview at the *New to the Sault/Sault Community Career Centre (SCCC)* space. (She had a young child, was pregnant, and did not drive.) After similar requests by many of the other participants, however, I realized that holding the interviews in the *New to the Sault/Sault Community Career Centre (SCCC)* space was likely to be more inconvenient and uncomfortable for most individuals, than holding them in the comfort of their own home. I discussed this with the *New to the Sault* team, and together, we judged that since I had access to a vehicle and it was easy for me to get around the city, it would be appropriate for me to do interviews in participants' homes, if they specifically requested this. To ensure my own safety as well as my participants', the *New to the Sault* team was aware of each of the interview's time and location. In addition, I always kept a cell phone with me, and I checked in with one of the settlement counselors following each interview, either in person (at the SCCC or at an external activity) or by phone. In addition, throughout the course of my fieldwork (e.g. when I was introduced to staff, when I attended *New to the Sault's* activities, when I made announcements about my study, when I took part in ESL support, etc.), but especially during the one-on-one interviews I was conscious of my positionality. As a white, English-speaking, Master's researcher from a renowned university, I was always well-aware of the fact that those around me could find me intimidating and/or give me some sort of special treatment. In order to minimize potential power imbalances, whenever I introduced myself to someone new, I did my best to link my research to my own experience as an im/migrant in Sault Ste. Marie, and to highlight my local connections. This often helped me to establish 'common ground' with *New to the Sault* staff and clients, and was also an effective strategy for developing rapport with interviewees. Finally, it is important to reiterate that the way in which the focus group took place was also unexpected and unconventional from an ethics standpoint. My main concern there was that once one group member asked if we could turn the English Conversation Circle session into a focus group, others might feel pressured to

participate. In order to minimize this pressure, I did not actively encourage this option, and highlighted the fact that I would be holding a separate focus group at a later date. I also observed all seven group members carefully for any signs of reluctance or discomfort as we discussed this. Noticing their excitement and enthusiasm to share their thoughts on the topic of my research right then and there, I agreed to their request, as long as all group members were in agreement and each completed a focus group consent document.

One limitation of this study is its focus on a very small sample of the immigrant population in Sault Ste. Marie Ontario. Although as little as 6 to 12 interviews can be considered enough to reach data saturation in anthropological and ethnographic studies (Guest, Bunce and Johnson 2006), I felt like I could have still collected quite diverse data, had I continued conducting more interviews beyond the 10 I was able to do. Moreover, the fact that the majority of the individuals who participated in interviews also participated in the focus group likely also lessened the diversity and complexity of my data, as well as my ability to guarantee data saturation. The quite spontaneous transition from a participant observation opportunity to a focus group likely also impacted my own readiness and ability as a facilitator and, by extension, the group dynamic, the way participants answered questions and the quality of the data obtained. Perhaps I could have obtained richer data had I simply continued to take more general notes on the group discussion as a participant observer. Finally, the opportunities I found for participant observation in general were not ideal. I was only able to spend a limited amount of time in each space and the nature of the activities that I took part in was sometimes unrelated to the exact topic of my research. Still, these activities yielded some significant fieldnotes.

Conclusion

In this chapter I have provided a rationale for my choice of fieldsite, including my own and my family's experience as im/migrants in Sault Ste. Marie, as well as links to recent literature which

resonated with this experience, and which inspired my research questions and study design. I provided an overview of the state of im/migration and settlement in that region, with particular attention to the growing im/migrant community and focus on im/migration over the last decade. Recent developments in the region include the emergence of the *New to the Sault* program which I partnered with to carry out my research. Finally, I described my methodology, including participant recruitment, in-depth, semi-structured interviews, a single focus group and 40+ hours of participant observation, and detailed some of the challenges and shortcomings of my study. I conducted a total of 10 one-on-one interviews and a single focus group. Participants were diverse: the majority were females between 31 and 40 years old, including individuals from Mexico, India, Japan, Indonesia, Germany, Spain, Pakistan and Argentina, and representing a variety of occupations. I also attended some of *New to the Sault's* public activities, including lunchtime get-togethers, weekly educational workshops and cooking classes. My interview questions as well as my observations focused on newcomers' perceptions, conceptions, expectations and opinions around health and well-being, health care, self-perception, self-worth, identity, belonging and deservingness, and also on what I understood to be some of the practical implications of these factors (e.g. interactions with non-newcomers on these topics, responses to conflicting perceptions, conceptions, expectations and opinions, etc.). My greatest challenges were logistical. Conducting my fieldwork during the summer months meant that potential participants were more likely to be unavailable or away for prolonged periods of time. For those who were available, transportation to suggested interview locations was an issue, and so alternate locations (with additional ethical concerns) had to be arranged.

CHAPTER 4: Findings

The role(s) of deservingness in ‘the right to health care’

This study began with three research questions: how do im/migrants in the Algoma region of Ontario understand or “reckon” health-related deservingness? How do understandings of deservingness impact their health and well-being? And, how do they negotiate deservingness? This chapter weaves together the data collected in response to each of these questions, a critical moral anthropological analysis and dialogue with the existing literature. First, I capture the range of im/migration experiences I encountered in the field. Then, I add complexity to the literature by describing participants’ conceptions of deservingness as different from their experiences of deservingness. Finally, I discuss the practical, embodied, subjective, and moral implications of participants’ experiences of undeservingness.

Through this analysis, I propose that experiences (as opposed to conceptions) of deservingness are at least as important a determinant of im/migrants’ overall health and well-being as formal entitlement and access. Furthermore, because experiences of deservingness are individual/localized, implicit and dynamic, they are more vulnerable to contextual influences and at the same time more ‘negotiable’. This ‘malleability’ of deservingness presents opportunities to re-think im/migrants’ agency, and the moral obligations and responsibilities of im/migrants and non-im/migrants alike.

Uncovering diversity

As described in Chapter 3, my experience growing up in and around Sault Ste. Marie had been of a relatively isolated, small and socio-culturally homogenous region. Moreover, prior to my fieldwork, I knew of only a limited range of pull factors attracting im/migrants to the region, and so I expected the diversity of participants in my study to also be limited despite efforts to recruit as heterogeneous a group as possible. In fact, I found a striking degree of diversity among people I interacted with throughout my

study. This was not only in terms of demographics, but perhaps more importantly, in terms of their im/migration journeys. Some had im/migrated to Canada based on promises of better work or education opportunities, others had come to join Canadian partners whom they had met elsewhere in the world, and yet others had simply been curious to experience life in a country different from their own. They had been post-secondary students, early-career workers, unmarried individuals, young couples looking to start families, wealthy or elderly retirees; engineers, bankers, architects, physicians, mothers, radio hosts, teachers and/or entrepreneurs. For most, Sault Ste. Marie had not been the place of arrival. Instead, they had ended up there following job transfers and/or a search for more affordable education, housing and lifestyle options than in larger urban areas, like the Greater Toronto Area (GTA) or Montreal. Some had settled in the city, with assistance from new employers including homes, vehicles and im/migration documents, while others had had the resources to, or had had little choice but to, navigate the settlement process on their own. Some had stayed in Canada for more than 10 years and others had only recently arrived. In the process, they had faced harsh new climates and unfamiliar physical environments, challenging languages and interesting new relationships, as well as unemployment, parenthood, isolation, mental or other health issues, family breakdowns and breakthroughs, and financial difficulties and successes, among the many challenges and rewards of im/migration. At least on initial interactions, all seemed to be content with their ‘new’ lives, often describing their host community as cold and snowy but quiet, calm and safe, and as a better option/opportunity than what they had had in the past.

Generally, it took little probing to transition conversations from focusing on individuals’ journeys to focusing on their health and health care experiences, since in many cases these experiences had been an integral part of the settlement process. Three interviewees (P1, P3 and P11) who had had young families upon arrival in Sault Ste. Marie or shortly thereafter, variously expressed that the necessity of enrolling their children in school and in the health care system had fostered some of their first meaningful interactions with non-newcomers. This had been, for example, by pushing them to seek out English language tutoring, get a driver’s license and “get out of the home”, in order to deal with principals,

teachers, service providers, authorities, etc. For another interviewee (P4), who had initially moved to the region on a temporary basis, signing up as a patient with a local family doctor had marked her decision to stay long term, and “made it feel permanent”. Similarly, others who had heard of Sault Ste. Marie’s health care resource shortages had experienced being admitted into a family doctor’s practice as a true breakthrough in belonging. One individual (P9) even stated that getting a good family doctor had been “like winning the lottery”, while another noted that the lengthy search for a doctor had given her something to discuss with other community members, and to connect with them on – something that made her feel “less foreign” (P5). Notably, all interview and focus groups participants had had at least one health-related experience in Canada.

The range of health-related experiences that participants spoke of, like the range of im/migration journeys, was quite broad. Moreover, while individuals’ explicit definitions of the terms *health* and *health care* were relatively narrow and did not vary greatly, their accounts of health-related events reflected a broader and richer experience of health and health care in each of their lives. For example, when asked to describe what *health* and *health care* meant to them, all interview participants alluded to two or more of the following elements: healthy eating, regular exercise, regular checkups, and access to a family doctor, treatment and/or emergency services. Often, they seemed to struggle to express what they were thinking. They paused, sighed in frustration, and said “it’s hard to explain...” (P2), or “health is everything! Like, eat healthy food, go to the doctor...I don’t know” (P3), as if the latter elements did not exactly capture all of what health and health care meant to them. This was likely not due to language barriers, as it was the case for people of various levels of English language fluency alike. Similarly, during the focus group, participants opted to define *health* and *health care* via a discussion of ‘healthy’ and ‘unhealthy’ habits of people in their home countries compared to those of people in Canada. Smoking and drinking alcohol were identified by the group as baseline ‘unhealthy’ behaviours, while having an active lifestyle and ready access to fresh, home-cooked food were considered as quite standard ‘healthy’ counterparts. On the other hand, when interviewees and focus group participants were asked to describe some of their first

health-related encounters in Sault Ste. Marie, they more effortlessly provided detailed accounts of everything from buying medicine for a common cold at the pharmacy, to getting a health card, finding a family doctor, dealing with depression, experiencing pregnancy and childbirth away from extended family, and scheduling minor surgery amid a shortage of resources and specialists. Adding further complexity, they readily (i.e. requiring little to no probing) compared these experiences to experiences they had had or would have had in their home countries. For one interviewee (P1), telling me about the “first-class service” she had received in a Sault Ste. Marie hospital throughout the birth of her first child, brought to mind the shortcomings of the health care system, and of the state more generally, in her own country. She explained:

“I have to compare the service here to the service I would have received in [my home country]. There, there would have been more delays. It would have been a very different process. I would have had to use a private service and I would have had to pay in full for the birth of my daughter. The public health care service in Canada, compared to the private services [in my home country], are similar, but against the public health care services, truly, [my home country] has disadvantages. To me, it’s a miracle that I was able to get everything that I got without paying a cent”.

She later also related the “disadvantages” of the health care system in her home country to widespread state corruption, noting that in the health care system, like in the workplace there, there are many barriers for “people who don’t have connections”. These thoughts were echoed by four others (P2, P5, P6, and P11), who also likened the quality of the Canadian public health care system to that of private services in their home countries. One of them (P11), speaking of her first visit to the emergency room with her youngest child in Sault Ste. Marie, said: “at least the hospital has everything here. [In my home country], the day I took him to get his first shots at the public hospital, I thought ‘is the roof going to fall down?’ They didn’t even have gauze. Public hospitals there don’t get much money.” Another (P2) made an entirely different connection. He noted that the health care system in his home country “is not so good, and even when it’s good, people can’t afford it. But the difference is that people there are less individualistic. They work together more to help each other out, even with health”. Conversely, two other

interviewees (P4 and P8) from wealthier regions of the world both mentioned that their first encounters with health care in Sault Ste. Marie, which included long wait times, lack of resources, poorly trained health care professionals, etc., reminded them to be appreciative of the health care systems they had enjoyed in their home countries. At the very least, these initial responses broadened my ideas of what types of experiences might qualify as health and health care experiences for different individuals. Perhaps more importantly, the complexity of the responses and of the experiences themselves highlighted the multilevel and multidimensional nature of health, health care, and likely also of understandings of deservingness, in this ethnographic context.

Complicating deservingness

At its core, this research was motivated by the question of how people understand and experience the various dimensions of ‘the right to health care’. In one of the key studies that inspired my work, Willen (2012a) suggests that these dimensions include not only entitlement and access, but also local, everyday assessments of deservingness, which can influence how entitlement and access play out. Like Willen (2012a), Larchanché (2012) and Quesada (2012) in various locales around the world, I found evidence of the interaction and impact of these three dimensions in the lives of im/migrants in the Sault Ste. Marie area. Importantly, Willen (2012b) distinguishes conceptions of health-related deservingness from formal assertions of entitlement and practical questions of access (805). Whereas entitlement and access are anchored in formal juridical discourse and thus presumed to have universal relevance, deservingness, she suggests, is a “vernacular moral construct” dependent on individual and contextual particularities (Willen 2012a, 814 and Willen 2012b, 805). My research shows, however, that in practice this distinction is less clear than Willen theorizes it to be. I found that participants’ conceptions of deservingness did not necessarily reflect their experiences of deservingness, and vice versa. They claimed

deservingness on the basis of formal entitlement, but they experienced deservingness based on self-perceptions and subjective assessments of self-worth relative to others and to contextual factors.

In keeping with a multilevel and multidimensional perspective, my interviews and focus group approached health-related deservingness from multiple angles. I asked questions about deservingness directly, such as “Do you feel that you/immigrants deserve access to public services like public health care? Why or why not?” I also inquired indirectly about self-perception and self-worth (see Appendices A and B), as reflective of broader conceptions and experiences of deservingness. Certainly, I expected responses to each type of question to be different; richer for the latter, more open-ended and inclusive questions than for the former questions, as I saw with health and health care. But the contrast I observed is beyond the type or structure of the questions asked, and greater than I expected.

Conceptions of deservingness

When asked the more direct questions, respondents consistently linked deservingness to various forms of formal entitlement, rather than expressing feelings or describing moral assessments. They claimed deservingness based on one or more of the following reasons: they had legal im/migration status and documents, they had a health card or health insurance, and/or they were workers and thus taxpayers. For two individuals (P4 and P2), for example, the logic was simple: “each person deserves what they work for. If you work the hours you are supposed to work, you should have employment insurance, access to doctors, etc.” and “if they [im/migrants] have a health card, then it should be easy to access the doctor”, respectively. Having a health card also marked deservingness for at least two others. One interviewee (P1) explained that getting a health card and being additionally insured by her spouse’s employer had indicated to her that she “should be treated as an equal” when accessing health services. In addition, one focus group participant (P8) firmly stated that “if a person has a health card, there is no question; they should get the health care any Canadian gets”. The rest of the group nodded in agreement

and shared experiences consistent with her view. Others, instead, described a sort of continuum of deservingness based on im/migration status. One individual (P11) explained that deservingness “depends on why people come here [to Canada]”. She continued:

“we came to work, we did everything you should do, legally, to have the permanent residency and the health benefits. We worked, paid the taxes and the money for the documents, filled out the papers, everything. Some people just come to study or like my parents, they came to visit many times, so, of course, they don’t have the same rights”.

Another individual (P2) described the continuum candidly. He said:

“I think it’s like if you invite someone to visit your house, they are just visitors, so they shouldn’t have the same as you. But if they live with you and pay for some of the house, they get responsibilities but also benefits. So, visitors should pay because you’re just visiting. Workers pay into the system, so they should be covered. But I don’t think that students should have to pay extra for UHIP [university health insurance plan] because higher education is already so expensive. And then permanent residents; I think they should have the same as citizens. I think they deserve this because it’s a long hard process to get the residency documents and they also have to pay taxes”.

For both, deservingness seemed to be something quite clear, matter-of-fact, and/or common sense – “of course”, linked to im/migration status. Similarly, a few others reacted to my question with some surprise, presumably, because they considered the answer to be quite obvious. Two people, in fact, reacted very similarly. One (P4) exclaimed, “[im/migrants] deserve what they deserve, what else can I tell you...” and the other (P3) stated, “[im/migrants] deserve what they have. There is not much option [in Canada]”. In addition, focus group participants, each with their own reasoning, responded to the same questions with an undoubted and resounding “yes”. Responses were likely influenced by individuals’ frequent and, in some cases, quite recent encounters with bureaucratic entities that emphasize the importance of formal juridical documents and processes (for example, passport, visa or citizenship applications, driver’s license, social insurance number, and/or health card issuing, banking, real estate purchases, etc.). Responses were also consistent regardless of demographics, of time spent in Canada, and of whether the individuals came from developed countries with welfare systems similar to that of Canada, or from less

developed regions of the world. Moreover, in most interviews, I offered two versions of my main question: “Do you feel that you/immigrants *deserve* access to public services like public health care?” and the slightly less complex, “Do you feel that you/immigrants *should have* access to public services like public health care?”. This was to ensure interviewees with more limited English language fluency understood what I was asking, and also to determine whether wording options influenced the richness of responses at all, but there did not seem to be any effect.

Experiences of deservingness

Questions about self-perception and self-worth, on the other hand, revealed experiences of deservingness – feelings of confidence, belonging and worthiness or guilt, shame, fear, uncertainty and unworthiness – which included few or no explicit links to formal entitlement. This was not entirely surprising, considering the more open-ended and inclusive nature of the questions. What was indeed unexpected was that individuals’ experiences of deservingness did not always align with their deservingness claims. That is, despite their claims of deservingness described above, not everyone recounted feeling deserving in everyday life. Moreover, it was at this experiential level more so than at the conceptual level that historical, socio-cultural, political as well as individual or local influences on deservingness, similar to those described by Willen (2012a) and Fassin (2012), were evident.

Especially in the earliest stages of im/migration and settlement, participants’ self-perceptions, and by extension, their experiences of deservingness to health care had been shaped by: local discourse about im/migrants and about the health care system, and close relationships which informed their understanding of the community and of their place in it. With little else to ‘go on’ in a new environment, individuals had been particularly affected by what people local to Sault Ste. Marie said about them and about health care. One interviewee (P1), for example, described that when she first arrived in the city, she had felt like she had to “be invisible or keep a low profile”, and had feared and avoided going out into the community

because someone might “detect” her and ask “what are you even doing here?”. When I asked why she had felt this way, she explained:

“When I first got here, I started taking English classes...My teacher took us to a conference on newcomer issues since we were all newcomers. That’s where I first heard many Canadians complain that we were coming from other countries to take their jobs. That’s when I also realized that many others also probably think that too. And to some extent, I didn’t blame them. I would think the same in my country, if other people came and they were given the same opportunities that we get here. So at first, I was very impacted by this, especially since physically, we don’t look like Canadians”.

Her discomfort and fears had not only been influenced by Canadians’ opinions, but also by those expressed by other im/migrants who had been in Sault Ste. Marie longer than her. She continued, “I had also heard many negative comments from the Latino community about other people in the community who look down on you or don’t think you should be here, so that scared me about using health care too”. Similarly, another interviewee (P11) traced a negative self-perception and feelings of undeservingness back to the time when an English language tutor who complained to her about “all the illegal im/migrants in Toronto who make gangs and deal drugs”. Thinking back to this, she stated: “I couldn’t believe it! I thought: I am white but I am an im/migrant too! I was paralyzed. I felt very small, very bad. I stopped going [to the tutor’s class] for a while”. Shortly thereafter she “felt even more alarmed” when she heard about a friend’s first health care encounter. She recounted:

“She got the flu and had to go to emergency. She told me she had to pay a lot of money for this and that people didn’t try to help her. At first I thought: if it’s really like that, and I have to pay, I shouldn’t go to the doctor, that’s too much. But you have to understand, she hadn’t taken the time to process her [im/migration] papers and health card. That was partly up to her, how long she took to do that. When my husband and I had to do it, it didn’t take long, it was just a question of getting it done. It sounds bad to say but it’s true”.

While not everyone had been witness to overt, negative comments about im/migrants, most of the people I spoke with had at least heard of health care resource shortages and of how difficult it is for newcomers to feel truly integrated into the tight-knit Sault Ste. Marie community despite the generally friendly nature

of local residents. One interviewee (P3) noted that these types of comments had made her feel “too sensitive”. She explained:

“my children had a very hard time at school at first, making friends, and sometimes people didn’t even say ‘hello’ at the grocery store. I know, there are more kind and less kind people everywhere, but I felt offended, I felt bad for them [the children], and I thought that maybe I had made a bad choice to come to Canada”.

Later, she “dreaded” having to look for a family doctor or take her children to the doctor because she was afraid how she and her family would be treated by people throughout the community. For one of the focus group participants (P6), instead, such comments had produced guilt. He recounted:

“I was hearing so much that there are no doctors, the hospital is bad, you have to wait, and this and that; when I went to the emergency for some pain and the doctor gave me some pills for free, I felt bad. In my country nobody gives me this for free, doctors are greedy, there is corruption. I said, ‘who’s going to pay for this?’. Even when I bought the medicine at the pharmacy, it was cheaper [than in my home country]”.

Beyond the interviews and focus group, conversations about health care issues occurred often and quite spontaneously. Those who had recently arrived at the time I spoke with them seemed especially eager to discuss health care issues, even without my explicit prompting. For them, such conversations seemed to provide opportunities to learn about their new community and their own place in it. For instance, a brief exchange about a health issue my father was going through at the time sparked a series of other questions about medical education and the quality of local health care services, from a newly arrived couple. Each time we met after our first community garden lunch together, our conversations quickly gravitated to one of these topics. Most often, they looked to me and to others who had been in Sault Ste. Marie longer than them for insight, or to confirm or dispel comments they were beginning to hear throughout the community. Similarly, after I briefly shared the topic of my research during one of the *New to the Sault* workshops, two other newcomers approached me repeatedly with various questions about and keen interest in my work. During another lunch gathering, I also observed a group of newcomers laugh in agreement when someone described health care-related frustrations as akin to

weather-related frustrations in Sault Ste. Marie. They implied that both are key features of the community, and therefore, that talking regularly about both is key to community membership.

Experiences of deservingness beyond the health realm seemed to depend more specifically on individuals' sense of self-worth. And in turn, self-worth seemed to be understood as a function of: economic contribution to the community, independence/self-sufficiency and approximation to idealized 'Canadian citizens'. In a telling example, when asked how she felt about her place in the community, one interviewee (P11) explained:

"I have been in Sault Ste. Marie for almost twelve years. And for me, re-constructing a new identity -- that was the real challenge! I think this is more for people with families who must deal with others first, like me. In the beginning my children were young so I could only take care of them, but then I wanted to find something for myself. Only when I embraced the English language, when I understood the Canadian's mind, when I learned how to apply for a job and to write my résumé from that perspective, then I got a job and then, after 10 years, finally I felt like a human again. My work is not exactly the same as before but I am happy. Now, I want to have more responsibilities in my job".

Re-constructing an identity and a sense of self-worth had also been a challenge for various other women who were mothers and who had relocated to Sault Ste. Marie due to new employment or other opportunities for a spouse or partner. One of them (P1) remarked:

"Integrating myself within the community has been really a challenge, but I accepted it. My greatest issue has been the fact that I haven't worked and I didn't really have the language to work, so I spent a lot of time at home, and I didn't get to see a lot of people. Just now, after three and a half years I'm starting to go out on my own a bit more, to make new relationships, and to feel more confident that I can be something here. I had a good job working at a bank. Maybe I will not do the same but I want to do something. But, again, it was up to me. I decided to stay at home with my daughter and not work because I don't have great English. I want to have a better level. And also I think that it's important for me to work because then I can also generate new employment, in other sectors, for example, I can buy a house, go to the grocery store, or go to the gym and I can pay taxes like other citizens here. So that makes feel better about being here; like I'm not taking someone's place".

Another (P9), recalled her own and her friend's similar experiences:

“The time when you come here and you have to stay at home and take care of the house and the kids, and cook, it can be very depressing. You don’t have time for yourself so you start to feel very closed off. I am a very social person, so I thought I would come and I would have lots social circles. But it takes time and it’s not easy here, especially in the winter. I was lucky that I am stubborn; I made some connections and found my job, even if it doesn’t have much to do with my real profession. One of my friends; I had known her for a long time, but when she finally got a job that she wanted, it was like she was a different person. I couldn’t believe it. Now she is confident, she goes to all the community events, she knows people. But you have to push to get what you want here, otherwise people don’t listen to you”.

The importance of formal employment and independence/self-sufficiency as a means of shaping or re-shaping identity, gaining a sense of self-worth and integrating into the community, especially for women, was also evident in contexts other than these interviews. Notably, not only is *New to the Sault* a program of the Sault Community Career Centre (SCCC), but it also has as one of its main objectives “to provide employment related services to support integration of newcomers into the community”. As such, it holds regular workshops and events that focus on developing job search- or employment-related skills, including networking, résumé building, language and literacy, as a pathway to settlement and integration. Although I did not attend any workshops that focused specifically on employment, I did attend the 2014 Local Immigration Partnership (LIP) “Racial Harmony” Immigration Forum, an annual, one-day conference put on by LIP members including *New to the Sault*, to inform the community on the LIP’s progress and on the state of im/migration and im/migration issues in Sault Ste. Marie. The forum focused heavily on providing an overview of Sault Ste. Marie’s aging and dwindling population, labour force shortages and industry prospects. Throughout the day presenters eagerly emphasized these as opportunities rather than issues: opportunities for employers to hire newcomers and for newcomers to settle and contribute to growth in the community. To illustrate this, four newcomers (three out of four of them female) were invited to share stories of how they had each found meaning in even the simplest of jobs: dog-walking, gardening, volunteering, etc. Other workshops and events I attended also included these types of stories, though less intentionally. During a workshop on real estate in Canada, for example, one of the presenters opened her talk and engaged the audience by recounting her own story as an

im/migrant, spouse and mother in Sault Ste. Marie. She had relocated to the city five years earlier with her husband, who had been transferred to work in the local manufacturing industry. With a spouse's income that could support the household, little opportunity to practice her prior profession, and young children at home, she had initially been happy to become a stay-at-home mother. But seeing the importance of contributing to the community in order to become a part of it had soon motivated her to pursue real estate training. As a real estate agent she felt like she had fulfilled her dreams of a better quality of life, and could help other im/migrants settle in Sault Ste. Marie and do the same. On at least two other occasions I observed women allude to getting their first job in Canada as an important milestone in the settlement process. One did not quite have a job yet, but she beamed with pride as she announced to small group gathered for lunch that, after a long period of language preparation and résumé writing, she had her first ever interview lined up. Others in the group encouraged her and shared advice or their own stories of how first interviews and jobs had boosted their self-confidence and given greater meaning and value to their lives in Sault Ste. Marie.

Much like in some of the literature, for those who had not had the resources (language, qualifications, etc.) to be able to work outside the home, motherhood had provided an identity that seemed to make them feel more deserving than as women only. One interviewee (P1), for example, noted that she had chosen to get pregnant shortly after she arrived in Canada, partly because it could be beneficial in the settlement and integration process. She stated:

“I always wanted to have kids. But I also thought it was a good time because, you know, when you have kids, you have to go everywhere with them, the park, the school, the doctor, so you get out into the community more. And I have to say it's true after having my daughter! Now I have no choice. I have to confront my fears, learn to speak, ask for what I need. And people have to listen to me more because I have a child and she was born here”.

Similarly, another interviewee (P3) remarked that many of her friends had had children in Sault Ste. Marie, not only to take advantage of better health care and education opportunities, but also because it

allowed them to “establish roots and help to build the community”. She, in particular, had had her second child in the city. She expressed that this had eventually helped her and her first child “to adapt because the baby is Canadian”.

It was not only women, however, who saw ‘worth’ in formal employment and independence/self-sufficiency. One male interviewee (P6) remarked that he “could not bear to feel like a burden” after having been a successful engineer in his home country. Very quickly after his relocation to Sault Ste. Marie, he began to actively network and search for work opportunities. Even with a 40-plus year career behind him, he was still willing to pursue a new college degree or certification in a field unrelated to his profession, in order to achieve his goal of feeling “useful” again. Another male interviewee (P2) who had moved to Sault Ste Marie to be with a Canadian partner, highlighted the importance of being “proactive” in order to succeed in the settlement and integration process. He explained: “integration is actually really hard. People here will not ask you, invite you, help you, or hire you if you don’t ask. And that’s a problem for people who come from my culture because we usually don’t ask for things like that there”.

In addition, some men and women seemed to measure their ‘worth’ against idealized constructions of ‘Canadian citizens’; not only citizens local to Sault Ste. Marie, as alluded to in prior examples, but also ‘Canadians’ as a nation. When asked if and how her self-perception had evolved over her time in Sault Ste. Marie, one interviewee (P10) stated:

“Saying ‘hi’ to people and being honest, hardworking, organized, clean, or even just separating the recycling, and knowing that you have to pay taxes every year; all of that makes you more Canadian and different, better, from what you were at home. Because people are like that, that is the reason why everything works better in this country. After a while you start to see that those are your obligations if you want to have a life here. Even understanding that when it’s very cold outside, you can still enjoy it. You start to want to experience all of those things too. They make you feel more like a Canadian, like you are not just temporary here”.

Reminiscent of historical trends and national myths and narratives discussed in Chapter 2, another individual (P2) added that “Canada is a country built by immigrants, so everybody knows that they have

to welcome immigrants. They have to help each other, so everybody's really nice. And that means you should be really nice too". He continued:

"Some people don't think I know a lot about Canada, but sometimes I know more than them [laughs]; I've been here for a little while now and I'm learning how to be Canadian because I plan on getting the PR [permanent residency]. I don't want to be 'just a student' here anymore".

And similarly, a third interviewee (P1) stated:

"We chose to come to Canada because we considered it a much more noble country than the US. I have family there and I know it's very hard for them there. It has been a long process; lots of documentation, papers, money, but in the end you see the light. We see that the result is worth it. That's how we got here and we are happy. We are here on working visas but since our daughter was born here and now we're expecting a second child, we want to apply for the PR [permanent residency]. We want to stay. Of course, we miss home, family, culture, but that's the challenge of living in a different country. And, that's the challenge also for people here, who sometimes don't like that we are here. We pay taxes, we try to do everything right, like citizens, so we can stay".

Individuals' yearning to become more like 'Canadians' showed: in their commitment to perfecting their English language skills through countless ESL classes and conversation group meetings, in their hesitation to speak publicly of the challenges of im/migrating to Canada and thereby potentially devalue the opportunities this provided, and in their eagerness to learn about Canada, Canadians and Sault Ste. Marie from *New to the Sault* workshops, staff and other community members. It was perhaps even encouraged by workshop presenters, some of whom were friendly, inclusive, 'model' Canadians working to support im/migrants through settlement and integration processes; or similarly by community garden keepers who shared their space, tools, and lunches with *New to the Sault* members and staff in an effort to help make newcomers feel welcome.

Most of the people I spoke with had felt undeserving in some form – whether as guilt, shame, fear, uncertainty and/or unworthiness – and had grown to feel more deserving over time. There were two

significant exceptions. One interviewee (P4) explicitly stated that since arriving in Canada, she had never felt undeserving. She explained:

“Before I came to Sault Ste. Marie, I knew two things about the place: there is a lot of snow and people are very friendly. And it is exactly like that. I have always felt welcome. In fact, I never even thought of myself as foreign or an immigrant or that anyone would think that I shouldn’t be here. And with health care, I never thought that I wouldn’t be looked after or anything like that”.

She also attributed feelings of undeservingness to individual attitude more so than to experience and/or contextual factors. She continued:

“I truly believe that sometimes the feelings of undeservingness that immigrants have are a result of attitude. I had a positive attitude because I had already gone and survived through an immigration experience in England. I had already overcome those thoughts like ‘they think I’m an idiot because I don’t speak English or they don’t value me’. I was immune. I just didn’t care anymore. I didn’t believe it. I know I am better than that. But, I know, for me, immigration was fun, happy, an adventure. If I was a refugee, it would be totally different”.

Specifically with respect to health care, another individual (P8) jokingly stated during the focus group:

“I am terrified of going to emergency or to the doctor here, but not because I feel undeserving; I feel like I deserve more, better care than this! In my country, waiting for hours in emergency with a broken leg is a ‘no go’. Or if you need surgery, you go and you have it the next day. What happens here is unthinkable”.

Unlike the participants mentioned in previous examples of experiences of deservingness, who were all from developing regions of the world, both of these individuals were of Western European origin.

In addition to highlighting the distinction between deservingness as a concept and deservingness as an experience, these experiences of deservingness highlight a few important historical, political and socio-cultural and local influences. First, participants’ consistent references to economic productivity and independence/self-sufficiency as a measure of self-worth suggest that their experiences of deservingness are likely influenced by the long-standing and ever-present utilitarian agenda underlying much of

Canadian im/migration policy and practices. This influence includes not only national im/migration policy and politics which emphasize economic priorities and favour the most ‘productive’ im/migrants, but also the local-level push for economic growth based on im/migrant contributions in and around Sault Ste. Marie. Second, participants’ repeated allusions to idealized ‘Canadian citizens’ as models of worthiness, evoke the influence of Canadian identity narratives and nationalist mythologies that, as Mackey (2003) suggests, portray Canadians as law-abiding, compassionate and caring citizens committed to the values of diversity and multiculturalism. And third, the contrast between the responses of participants from developed regions of the world versus those of participants from developing regions, is perhaps indicative of a subtle racialization of deservingness; whereby im/migrants who are considered by non-im/migrants to be of the “charter” or “preferred” races (Porter 1965, 60, Li 2003, 16 and Thobani 2008, 12), or closest to, are more likely to have positive deservingness experiences than those who are not. This racialization of deservingness is consistent with and likely influenced by Canada’s history of discriminatory im/migration trends and practices, and the contemporary climate of criminalization, securitization and fear of ‘non-white’ im/migrants at national and global levels.

Practical and embodied impact

Regardless of formal entitlement and claims of deservingness, in practice, some participants had not always felt as deserving as others, and so they had not all exercised their health rights equally. In fact, my findings mirror the existing literature on the impact of undeservingness experiences for ‘undocumented’ im/migrants (for example, Quesada 2012). Most commonly, participants’ feelings of undeservingness had resulted in avoidant behaviours, such as: waiting as long as possible before seeing a health care professional for persistent, disabling and/or potentially life-threatening health issues, looking for alternative or informal care options, and avoiding illness or pain at all costs in the first place. For one interviewee (P1), for example, the fear and shame caused by local discourse about im/migrants and the

health care system had been such that she had waited until the very last minute before going to the hospital to give birth to her first child. When asked to describe the experience, she explained:

“My pregnancy was pretty straightforward. This was despite all the negative comments I was hearing, like at the newcomer conference. But so many of those types of comments generated a lot of fear before the birth. So much that when the day came, I was terrified of going to the hospital. I didn’t know how they would treat me and my baby, you know. So, my greatest fear was really, that day, when I went to see my family doctor, when I started having contractions, and he told me to go to the hospital, and there they would tell me if I should stay to have the baby or not. In fact, I didn’t want to even go to the hospital at all. I thought: ‘I’ll just stay at home until the contractions progress a bit more and then we’ll see’”.

Moreover, in line with Willen’s work, the embodied impact of her feelings of undeservingness was both epidemiological and phenomenological. While her actions had not had any life-threatening consequences, she had endured unnecessary physical and psychological distress, and in hindsight, blamed only herself for it. She added:

“Looking back on this I realize that because of those types of comments and preconceptions, you put yourself at risk. I was in a lot of pain and I was tired when we finally went to the hospital. If I waited long enough, I may not have made it to the hospital to have the baby, especially because it was our first child and we didn’t know what types of signs we should watch for when the baby was ready. So you think: how can it be that just from those negative comments I could have endangered my baby’s life or my own? Simply due to fear and worry about how they would treat me at the hospital? Instead, the day of the birth I arrived at the hospital and everyone took very good care of me – at the reception, the nurses, even though some of them had to change shifts. The three nurses who were in charge of me, took very good care of me and also of my child. After that, I realized that the actual services provided were not bad, compared to what I had heard and to what other women close to me had experienced. From then on, my perspective changed a little bit, but for some reason I was still a little bit afraid”.

A focus group participant (P6) reported having delayed one of his first visits to the doctor for similar reasons and with similar consequences. As a result, his condition had worsened, and later, he blamed himself for what were more likely shortcomings of the health care system. He stated:

“I started with really bad pains in my stomach, vomiting, etc. I should note, I generally don’t like to go to the doctor, and I still had a bit of fear that they wouldn’t listen to me or understand me because I’m not from here. A friend had told me that if you have minor

pain you have to wait forever to get an appointment with the family doctor and usually they just give you some Tylenol. I thought: ‘Why am I even going to go?’ So, I spent 3 months avoiding going to the doctor. Three months of a lot of pain and vomiting. They got worse. Eventually, I had to go to emergency. They were pretty quick. There were a lot of people there but it didn’t take them more than 2 or 3 hours. I was also able to stand the pain for that time. Everything was ok until they said that I had to see a specialist so that they could tell me more about what I had. That was when the delay happened. That was in February and they told me the specialist couldn’t see me until August and they couldn’t do much to manage the pain. But I accepted this; because when I got sick I didn’t even try to go knock on the hospital doors. If I had, maybe I wouldn’t have had to wait so long. I can’t be sure, but I also can’t say it was their fault that there was such a delay. I accepted their diagnosis and referral, and I accepted living like that until the following appointment date. I can’t blame the service. Everybody has to do their part. If I don’t value the service I’m given, they’re not going to give it to me at all”.

Thinking back to when his wife received two incorrect diagnoses before being referred to a specialist for a skin condition, he added: “We trusted the doctor. We thought: ‘she looks confident, so she must be right’. But now I realize that we should have asked more questions, investigated more. I can’t say it was her [the doctor’s] fault there either”.

The negative reputation of local health care services combined with concerns about how they would be treated, had been motivation enough for two others to seek alternative health care options. One interviewee (P2) explained:

“I once had an issue with my ear. I was not a student yet, just a visitor, so I was concerned about using the health services, and somebody told me that I would have to wait a really long time and pay a lot of money because I needed surgery. So, I tried to look on the internet. You can sometimes cure it yourself because there are other people with the same issues. I tried some home remedies instead. I was lucky that it got cured eventually. It wasn’t smart because if it got worse, I would have paid more in the end, and someone told me later that the issue I had can be very risky”.

The other (P11) described the case of her husband, who had instead sought better-reputed but more expensive care in the US.

“My husband says that doctors here don’t know much, and just give ‘band-aid’ solutions, and they don’t care about us. We had heard similar stories from others. So, when he started having serious problems with his heart, he was scared that they wouldn’t do enough. We thought about going back home to see if they could do something better, but

then he just went to a very good place in the US and paid a lot of money, but now he is ok”.

Finally, two other participants (P3 and P9) had tried not to use local health care services at all.

One of them (P3) explained:

“It was hard to get a family doctor in the first place. I didn’t want to do it. I had heard many bad things about it and I didn’t know people in the community yet, I didn’t have any roots. I didn’t know how they would treat my children, especially since they were having issues making friends at school, so I was concerned. For some time, I made an effort to keep the children healthy, and wait to go to the doctor during vacations [in my home country]. But now, I have to say, my experience is more positive”.

The other (P9) stated: “to this day, I refuse to go to the doctor or the hospital! I only go if my kids have a serious emergency, so my experience with health care is not much”.

On the other hand, for one of the individuals (P4) who had not felt undeserving, first-time health care experiences had been more straightforward. She explained:

“When I first went to the doctor, I just went to a walk in clinic; I already had my health card. When we got here [to Sault Ste. Marie], it was a bit more complicated, but it had to do with the fact that there are fewer resources here. I used walk-in clinics until I found a family doctor. But really, having a family doctor before that would not have made a difference because they were mostly emergencies, so I would have had to go to emergency anyways. I realized how important the family doctor is when I had my children. I had my children at the hospital here and everything was pretty good. I can’t say I have any complaints”.

And, as mentioned earlier, the other individual (P8) had avoided using the local health care services – not because she felt undeserving, but because she felt she deserved better quality care.

Experiences of deservingness indeed appear to be an important dimension of ‘the right to health care’; at least as important, if not more, than entitlement and access. In fact, feelings of undeservingness are perhaps more powerful and pervasive than has been documented in the literature. Even in the more ‘regular’ im/migration context captured here, where most im/migrants have legal entitlement and

relatively easy access to health care, feelings of undeservingness seem to affect how people utilize health care, and ultimately, their health and well-being. Moreover, participants' responses show that while feelings of undeservingness may be only temporary, their impact can be long-lasting. That is, for some participants whose avoidant behaviours had worsened conditions or risk, self-blame persisted long after the fact. Finally, these findings suggest that those who have more positive deservingness experiences may have better health care experiences (i.e. with less risk, complications, stress, etc.) and overall health and well-being. This, however, should be more carefully investigated.

Negotiating deservingness

To answer my last research question – how do im/migrants negotiate deservingness in everyday life? – I draw on Zigon's (2012) *narratives* concept. In brief, Zigon describes narratives as words, utterances, acts, and gestures that allow people to 'feel' moral through situations or interactions which question their morality. As such, narratives can provide insight into individuals' own moral subjectivity, as well as their moral environment or moral issues and discourses therein. While it is unclear from the data whether or not participants had ever felt truly immoral with respect to their use of health care in Sault Ste. Marie, I think that Zigon's concept is helpful insofar as it highlights how participants worked to justify their deservingness, both in their everyday actions, and in hindsight, when I spoke with them.

Most participants alluded to having done something above and beyond formal entitlement to both feel deserving, and appear deserving to others in their host community. As illustrated earlier, some had worked hard to get jobs and get involved in the community; others who had not been able to work outside the home had established roots through parenthood; and yet others had made an effort to become more like 'Canadians'. Generally, we may think of most of these processes as quite typical and required steps in settlement and integration, but the way in which participants described them revealed a more subtle and significant meaning. In hindsight, people talked about them not as a given of settlement and integration,

but as pathways to feeling “useful” or “human again”, “not taking someone’s place”, and making something of or improving themselves. Participants’ actions and descriptions suggest that, at one point or another, they had perceived a sort of inherent undeservingness about being an im/migrant independent of formal entitlement, and had felt like they had to prove otherwise. In turn, these actions and descriptions also give us a sense of the im/migration ‘climate’ in Sault Ste. Marie, and in Canada more broadly; one that is perhaps less welcoming than we might assume it to be considering Canada’s commitment to im/migration, multiculturalism and humanitarianism. Based on what we know about im/migration history, policy and politics and public discourse in Canada, we might even suggest that this is a climate in which maintaining a humanitarian persona and advancing a utilitarian agenda likely take priority over subtle but important moral issues and moral subjectivities on the ground.

At the same time, participants’ actions and descriptions indicate that experiences of deservingness are more ‘negotiable’ in everyday life than entitlement, access and conceptions of deservingness. That is, while individuals may not be able to negotiate their im/migration status, health insurance documents or other forms of formal entitlement, they can make themselves feel deserving through everyday actions and decisions, like getting jobs and getting involved in the community, leveraging parenthood, and becoming more like ‘Canadians’. And, while having control over one’s own deservingness experience may not seem like much, it can serve as a form of agency. As demonstrated by the data, for some, it may make the difference between having a basic existence or a rich, healthy and comfortable one. Acknowledging this local, everyday form of agency, however, draws attention to the everyday “messiness” and realities of borders and migration (Heyman and Symons 2012, 543), and so requires an expansion of reductive and absolutist imaginations of ‘a border’ (Heyman and Symons 2012, 540). As such, it also places an onus on im/migrants and non-im/migrants, to think about and re-think their roles in transnational flows, relations or connections (e.g. postcolonial, geopolitical struggles) (Heyman and Symons 2012, 546), and to recognize and act on their moral obligations and responsibilities

therein. In the Sault Ste. Marie context in particular, it highlights the importance of individual action to filling gaps in im/migration and health care policy, and health care systems.

Conclusion

In this chapter I present the key results of my study. In line with Willen's (2012) work, my findings show that alongside entitlement and access, deservingness is a key dimension of 'the right to health care'. I propose, however, that deservingness, and the relationship among these three dimensions, are more complex than the literature has demonstrated thus far. Most importantly, I found a distinction between conceptions and experiences of deservingness. Participants' conceptions of deservingness seemed to be a product of conscious reasoning. They were generally tied to formal entitlement and thus applied to people in general. Experiences of deservingness, on the other hand, seemed to be more emotional, less conscious and linked instead to individual self-perceptions and assessments of self-worth. As a result, regardless of entitlement and access, experiences of deservingness affected how people utilized health care, and ultimately, were a determinant of health and well-being. Different from entitlement, access, and conceptions of deservingness, as well as more individual/localized, implicit and dynamic, experiences of deservingness were more vulnerable to historical, socio-cultural, political and individual or local influences, and also more 'negotiable'. As such, they present opportunities to re-think im/migrants' agency, as well as "new patterns of moral obligation" (Heyman and Symons 2012, 540), all of which may help to improve im/migrants' overall health and well-being.

FINAL CONCLUSION

This thesis is the combined result of: contemporary questions about the rights and merits of mobile populations around the world, my own personal experience as an im/migrant in an ever-changing Canadian and global im/migration landscape, and the experiences, opinions and insight that im/migrants in the Sault Ste. Marie area so kindly shared with me throughout my research. As such, it presents a quite unique perspective on the importance of moral dimensions of im/migration, health and health care.

At the very least, participants' voices help to expose subtle forms of discrimination, marginalization and social injustice occurring in Canada and worldwide. They confirm that it is not only those in 'irregular' im/migration situations and in far-off locales, who experience feelings of undeservingness with respect to health care; those in 'regular' situations may feel this way, too. In fact, even in an im/migration context as unlikely as Sault Ste. Marie, where most im/migrants have legal entitlement and relatively easy access to health care, people can feel undeserving. So much so that they may avoid seeking care at all costs, much like those in more 'irregular' situations often do. This is not to say that im/migrants in 'regular' and 'irregular' im/migration contexts experience deservingness equally, nor is it to say that local context has no influence on experiences of deservingness. As I have shown, at the local level, im/migrants in Sault Ste. Marie were clearly influenced by local discourses about im/migrants and health care, relationships with citizens and other non-citizens, and economic and social factors, like unemployment and health care resource shortages. But their experiences of deservingness and undeservingness emerged also from larger than local exclusionary influences that link the experiences of 'regular' and 'irregular' im/migrants. For example: the long-standing and ever-present utilitarian agenda underlying much of Canadian im/migration policy and practices, Canadian identity narratives and nationalist mythologies that "exalt" (Thobani 2008) Canadians as law-abiding, compassionate and caring citizens committed to diversity and multiculturalism, and a subtle racialization of deservingness, rooted in Canada's history of discriminatory im/migration trends and practices, and the contemporary climate of criminalization, securitization and fear of 'non-white' im/migrants at national and global levels.

In turn, participants' voices also help to contest such exclusionary influences, by demonstrating that im/migrants do not necessarily feel inherently entitled to health care, and may instead be willing to go above and beyond formal entitlement, to both feel and appear deserving to others in their host community. In Sault Ste. Marie, im/migrants got jobs and got involved in the community, leveraged their parenthood, and worked to become more like 'Canadians' to 'earn' their deservingness even when they did not have to. It is important to distinguish, however, that although this *knowledge* can be helpful, the fact that im/migrants may feel inherently undeserving in everyday life, is not. That is, im/migrants' willingness to 'earn' their deservingness even when they do not have to is not necessarily 'good' or 'appropriate' in and of itself. It is simply helpful insofar as it is indicative of misunderstandings or a lack of understanding of im/migrants' experiences, thoughts, actions, etc., and of significant gaps between universalizing juridical rights and localized experience.

Participants' voices also link experiences of undeservingness to very real, practical and embodied implications for im/migrants and potentially also for non-im/migrants. For im/migrants in Sault Ste. Marie, feelings of undeservingness manifested as prolonged physical distress and/or heightened risk for some, additional financial costs for others, unnecessary stress for those who tried to avoid health issues in the first place, and ongoing self-blame in cases where avoidant behaviours had caused worsened health conditions or risk. Moreover, while the research presented here did not focus specifically on non-im/migrants, we might reasonably expect that im/migrants' experiences of undeservingness can also affect non-im/migrants in various ways. Among other things, they may limit im/migrants' ability to participate in the community, pose barriers to care so subtle that they are difficult to understand and address, and create equally challenging inefficiencies in health care provision like additional financial costs, longer wait times, and stress and frustration for health care professionals and others who strive to provide the best care to im/migrants and non-im/migrants. With all of this in mind, stakeholders across the Ministry of Immigration, Refugees and Citizenship, the Ontario Council of Agencies Serving Immigrants (OCASI), local immigration partnerships (LIPs), immigration and settlement service providers, public health officials, etc., may consider developing initiatives that aim to improve

im/migrants' self-perception and sense of self-worth as a pathway to better health care provision and overall health and well-being for im/migrants and non-im/migrants. Within these initiatives, they may consider promoting preventive care specific to newcomers and supporting this with mentorship and education programs to help orient newcomers in the health care system.

Perhaps most importantly, this research highlights the complexity of the relationship among health-related entitlement, access and deservingness. Expanding on the work of Willen and colleagues (2012), my findings show that these dimensions of 'the right to health care' are not always easily distinguishable in the everyday lives of im/migrants. Participants' claims or conceptions of deservingness were generally tied to formal entitlement, while their experiences of deservingness were separately linked to self-perceptions and assessments of self-worth relative to others and to contextual factors. Experiences of deservingness were as important an influence on im/migrants' lives, as entitlement or access, if not more. In fact for most, moral personhood and moral worth, not legal status or practical access to care, made the difference between a basic existence, and a rich, healthy and comfortable one. While entitlement and access are marked by im/migration status, health insurance documents and the actions of service providers and authorities, experiences of deservingness are unique to each individual, mostly implicit and dynamic. As a result, they are also more 'malleable', at the local, everyday level than formal entitlement and access. Like Heyman and Symons (2012)'s *borderlands* concept, this 'malleability' of deservingness presents opportunities to re-think im/migrants' agency, and the moral obligations and responsibilities of im/migrants and non-im/migrants alike.

Recognizing deservingness as a dimension of 'the right to health care' is important because it can help to broaden our ideas of state, citizenship and inclusion/exclusion. It reminds us that individuals can not only experience political and social inclusion/exclusion, but also a sort of moral inclusion/exclusion; and that even this latter, more implicit type of inclusion/exclusion can have practical consequences. Moreover, it opens up the possibility of claiming inclusion, if not from a political community via formal rights, from a moral one via deservingness claims. This is ever more important amid contemporary

population flows, border securitization and migrant criminalization worldwide, where im/migration contexts are becoming increasingly exclusionary and the options for claiming inclusion, increasingly limited. By the same token, this understanding creates “new patterns of moral obligation” (Heyman and Symons 2012, 540). It places an onus on non-im/migrants, as individuals and members of the same moral community to look beyond universalizing rights, to im/migrants’ localized experience, and to respond to deservingness claims. This responsibility may not be easy to assume, but becoming critically aware of the complex links between our macro-social (i.e. policies and politics) and micro-social (i.e. moral beliefs and practices) (Fassin 2012) environments is, perhaps, a start.

With attention to local experience and links between the micro- and macro-social at its core, ethnography will be essential to the ongoing study of deservingness. In this particular study, an ethnographic approach revealed the very subtle difference between participants’ conceptions of deservingness and their experiences of deservingness, and helped to elicit the types of moral reasoning that they used to justify their deservingness, when these elements were not clear even to participants themselves. Deservingness warrants in-depth, detailed observation and description especially because it is so implicit. In the future, interdisciplinary research will also be important, particularly to gain a better understanding of the practical and policy implications of recognizing deservingness as a key dimension of ‘the right to health care’. Finally, this thesis points to the deservingness perspectives of non-im/migrants, the racialization of deservingness, the role of pregnancy and childbirth as a pathway to deservingness for women with limited resources, and links or commonalities between the deservingness experiences of im/migrants and Aboriginal Canadians, as potential topics for further study.

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APPENDIX A

Updated Test Instrument 1

Interview Questions

The im/migration journey

- 1) When did you come to Canada? How?
- 2) Why did you decide to im/migrate to Canada?
- 3) Can you describe the experience?
- 4) How is your life different now? What do you like/dislike about living here?

Self-perception

- 1) In general, how do you think people in Canada view im/migrants (for example, as portrayed in public opinion, the media, politics, etc.)?
- 2) Do you agree or disagree with these views? How so?
- 3) How do people in Sault Ste. Marie view newcomers? How did locals receive you when you first arrived? Have people's views of you changed over time in any way, and if so, how?
- 4) What do you see as your main role/contribution to the community?
- 5) Do you think that others in the community value your role/contribution? How so?

Response to individual and perceived moral judgments

- 1) How do people's opinions of you as an im/migrant (as per responses above) make you feel?
- 2) Do they impact your life in any way?
- 3) Can you give an example of one or two particular opinions you have heard about yourself or about im/migrants in general and how you responded?

Health-related deservingness and impact on experiences of health and health care

- 1) Tell me about an experience where you or someone in your family got sick in your home country.
- 2) What did you do? Did you go anywhere for help?
- 3) Have you or anyone in your family used health care services in Sault Ste. Marie or elsewhere in Canada?
- 4) What did you expect of the local health care services before you used them? How was your experience the same as or different from your expectations?

- 5) Do you think that people's opinions of you as an im/migrant affected your expectations or experience in any way? Do you think they affect your health in any way?
- 6) As an im/migrant, do you feel that you should have/deserve access to public services like public health care?
- 7) Do you think everyone should? Why or why not?
- 8) Do you think people in the community or in the rest of Canada would generally agree with you? Why or why not?

APPENDIX B

Updated Test Instrument 2

Focus Group Probing Questions

The im/migration journey

- 1) Please start by introducing yourselves and sharing your im/migration journey or story: When, how and why did you come to Canada?
- 2) Can you each name one way in which your life is different now from what it used to be?
- 3) Can you each name two advantages and two disadvantages about im/migrating to/living in Sault Ste. Marie specifically?

Self-perception

- 1) How do you think people in Canada view im/migrants (please share examples you have seen in public opinion, the media, politics, etc.)? Do you agree or disagree with these views? How so?*
- 2) How are those views similar to/different from views you have heard from people in this community?*
- 3) Do you feel that people in this community generally value im/migrants? Please explain why or why not.*

*Allow time for agreement/disagreement among group members.

Response to individual and perceived moral judgments

- 1) How do you respond/have you responded to these types of views? Use examples given above to elicit responses.

Health-related deservingness and impact on experiences of health and health care

- 1) Briefly describe what the word 'health' or 'being healthy' means to you.
- 2) If you've used health care services in Canada and feel comfortable doing so, please share an example of a positive or negative experience you've had with these services or service providers.
- 3) What did you expect of the local health care services before you used them? How was your experience the same as or different from your expectations?
- 4) Do you think that people's opinions of you as an im/migrant affected your expectations or experience in any way? Do you think they affect your health in any way?

- 5) As im/migrants, do you feel that you should have access to public services like public health care? Why or why not?
- 6) Do you think that everyone should? Why or why not?
- 7) Do you think people in the community or in the rest of Canada would generally agree with you? Why or why not?

APPENDIX C

Sample Consent Form for Interviews



INFORMATION LETTER & CONSENT TO PARTICIPATE IN RESEARCH

Exploring moral dimensions of “the right to health care”: Perceptions of health-related deservingness among im/migrants in the Algoma region of Northern Ontario.

You are asked to participate in a research study conducted by Lucia Frecha, student researcher, from the Sociology and Anthropology Department at the University of Guelph. Dr. Renee Sylvain is the faculty advisor for this project.

If you have any questions or concerns about the research, please feel free to contact Renee Sylvain at (519) 824-4120 ext. 52721 or rsylvain@uoguelph.ca or Lucia Frecha at (519) 362-9123 or lfrecha@uoguelph.ca.

PURPOSE OF THE STUDY

I (Lucia Frecha) am completing this study as part of the requirements for the Master's in Public Issues Anthropology and International Development Program at the University of Guelph. The results of this study will contribute to my Master's thesis.

In this project, I wish to speak to immigrants living in Sault Ste. Marie, Ontario, and the surrounding area about their health and health care experiences in Canada. The information provided during interviews or group discussions will help me learn about how im/migrants (immigrants and migrants) experience health care services in their host community. I am especially interested in issues connected to im/migrant relationships with health care professionals, such as dignity, respect, cooperation, and the type of consideration im/migrants feel they deserve from health care personnel. The results of this study may be published in academic journals. At no time will your names and other

personal information be shared with any other person, or included in my report or publications.

While I am conducting this research, I will be volunteering with New to the Sault (from June to August, 2014). I will assist New to the Sault staff with preparation and set-up of major events, and will help lead English conversation groups. This will help me understand some of the issues im/migrants face in the community, as well as the community life they build together. Although I hope to learn a lot about im/migrant community life from these activities, I will not use any confidential information I may acquire through these activities in my study.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

- Participate in an interview that will last approximately 1 hour, in a private office in the New to Sault Centre.
- During the interview, answer a series of questions related to your experiences as an immigrant in Sault Ste. Marie (and area), and your feelings and opinions about health and health care (particularly in Canada).
- Note that follow-up will not be required
- Note that findings may be made publicly available (i.e. in scholarly journals). Published information will not contain any direct links to your as a participant in the study.

POTENTIAL RISKS AND DISCOMFORTS

Since this research deals with personal experiences of health and health care, it may involve some sensitive questions. You are free to skip any question you would prefer not to answer and to withdraw from the project at any time.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

This research project may benefit participants directly by providing a space to speak about positive and negative experiences related to health and health care. If the study findings reach stakeholders, activists, policy-makers, etc. it may produce immigration or health policy change, or other interventional programs/activities that might help alleviate barriers to health care for immigrants.

PAYMENT FOR PARTICIPATION

You will receive a payment of \$15 for your participation in this study. You will also be reimbursed for any travel costs incurred (up to a maximum of \$50).

*I have received a payment of \$15 for my participation in this study.

Estimated travel costs \$ _____

Amount of travel costs reimbursement \$ _____

Participant Signature: _____

CONFIDENTIALITY

At no time will participants' names and other personal information be shared with any person other than the research team (Lucia Frecha and Renee Sylvain). Codes will be used in the field notes and report produced. Interviews will be audio recorded. Recordings will be destroyed when the project has been completed. During the course of the study and report write-up, all the data, including audio recordings of the interviews, will be kept on an encrypted computer in a secure location, which can be accessed only by the interviewer.

Please do not share any personal information regarding immigration status that you do not feel the researcher should know (e.g. controversial or "irregular" immigration status). Such information may be reported to authorities. Please do not disclose any personal information (e.g. medical history, health records, or specific health issues) that you do not feel comfortable sharing with the researcher.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. Your decision to participate, or not to participate in this study, or what you say during the project, will not affect the services you receive from New to the Sault. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may withdraw at any point after the interview has been completed, until this research has been published or otherwise disseminated. After the interview has been completed, the request to withdraw may be communicated to the student researcher, Lucia Frecha, via e-mail or phone at (519) 362-9123 or lfrecha@uoguelph.ca.

You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise that

warrant doing so. The investigator may withdraw from this research if circumstances arise that warrant doing so.

RIGHTS OF RESEARCH PARTICIPANTS

You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact: Director, Research Ethics; (519) 824-4120, ext. 56606; sauld@uoguelph.ca

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided for the study *Exploring moral dimensions of “the right to health care”: Perceptions of health-related deservingness among im/migrants in the Algoma region of Northern Ontario*, as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Name of Participant (please print)

Signature of Participant

SIGNATURE OF WITNESS

Name of Witness (please print)

Signature of Witness

Date

APPENDIX D

Sample Consent Form for Focus Group



INFORMATION LETTER & CONSENT TO PARTICIPATE IN RESEARCH

Exploring moral dimensions of “the right to health care”: Perceptions of health-related deservingness among im/migrants in the Algoma region of Northern Ontario.

You are asked to participate in a research study conducted by Lucia Frecha, student researcher, from the Sociology and Anthropology Department at the University of Guelph. Dr. Renee Sylvain is the faculty advisor for this project.

If you have any questions or concerns about the research, please feel free to contact Renee Sylvain at (519) 824-4120 ext. 52721 or rsylvain@uoguelph.ca or Lucia Frecha at (519) 362-9123 or lfrecha@uoguelph.ca.

PURPOSE OF THE STUDY

I (Lucia Frecha) am completing this study as part of the requirements for the Master's in Public Issues Anthropology and International Development Program at the University of Guelph. The results of this study will contribute to my Master's thesis.

In this project, I wish to speak to immigrants living in Sault Ste. Marie, Ontario, and the surrounding area about their health and health care experiences in Canada. The information provided during interviews or group discussions will help me learn about how im/migrants (immigrants and migrants) experience health care services in their host community. I am especially interested in issues connected to im/migrant relationships with health care professionals, such as dignity, respect, cooperation, and the type of consideration im/migrants feel they deserve from health care personnel. The results of this study may be published in academic journals. At no time will your names and other

personal information be shared with any other person, or included in my report or publications.

While I am conducting this research, I will be volunteering with New to the Sault (from June to August, 2014). I will assist New to the Sault staff with preparation and set-up of major events, and will help lead English conversation groups. This will help me understand some of the issues im/migrants face in the community, as well as the community life they build together. Although I hope to learn a lot about im/migrant community life from these activities, I will not use any confidential information I may acquire through these activities in my study.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

- Participate in a focus group involving 6-10 people, which will last between 1.5 to 2 hours, in a private office in the New to Sault Centre.
- During the focus group, answer a series of questions related to your experiences as an immigrant in Sault Ste. Marie (and area), and your feelings and opinions about health and health care (particularly in Canada).
- Note that follow-up will not be required
- Note that findings may be made publicly available (i.e. in scholarly journals). Published information will not contain any direct links to you as a participant in the study.

POTENTIAL RISKS AND DISCOMFORTS

Since this research deals with personal experiences of health and health care, it may involve some sensitive questions. Note that a focus group is essentially a public discussion, so you are invited not to say anything you would not feel comfortable making public.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

This research project may benefit participants directly by providing a space to speak about positive and negative experiences related to health and health care. Participants may benefit indirectly from this study, if the study findings reach stakeholders, activists, policy-makers, etc. and produce immigration or health policy change, or other interventional programs/activities that might help alleviate barriers to health care for immigrants.

PAYMENT FOR PARTICIPATION

You will receive a payment of \$15 for your participation in this study. You will also be reimbursed for any travel costs incurred (up to a maximum of \$50).

*I have received a payment of \$15 for my participation in this study.

Estimated travel costs \$ _____

Amount of travel costs reimbursement \$ _____

Participant Signature: _____

CONFIDENTIALITY

At no time will participants' names and other personal information be shared with any person other than the research team (Lucia Frecha and Renee Sylvain). Codes will be used in the field notes and report produced. Focus group discussion will be audio recorded. Recordings will be destroyed when the project has been marked. During the course of the study and report write-up, all the data, including audio recordings of the focus group discussion, will be kept on an encrypted computer in a secure location, which can be accessed only by the interviewer.

Please do not share any personal information regarding immigration status that you do not feel the researcher should know (e.g. controversial or "irregular" immigration status). Such information may be reported to authorities. Please do not disclose any personal information (e.g. medical history, health records, or specific health issues) that you do not feel comfortable sharing with the researcher.

Again, because this is a group discussion, the research team cannot guarantee confidentiality – please respect other participant's privacy, and do not discuss who attended or what was said during the project.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. Your decision to participate, or not to participate in this study, or what you say during the project, will not affect the services you receive from New to the Sault. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may withdraw at any point after the focus group has been completed, until this research has been published or otherwise disseminated. After the focus group has been completed, the request to withdraw may be

communicated to the student researcher, Lucia Frecha, via e-mail or phone at (519) 362-9123 or lfrecha@uoguelph.ca.

If you choose to withdraw, you will not be able to request or remove your individual data upon withdrawal, because it will be too difficult to separate from the group conversation.

You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise that warrant doing so. The investigator may withdraw from this research if circumstances arise that warrant doing so.

RIGHTS OF RESEARCH PARTICIPANTS

You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact: Director, Research Ethics; Telephone: (519) 824-4120, ext. 56606; E-mail: sauld@uoguelph.ca

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided for the study *Exploring moral dimensions of “the right to health care”: Perceptions of health-related deservingness among im/migrants in the Algoma region of Northern Ontario, as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.*

Name of Participant (please print)

Signature of Participant

SIGNATURE OF WITNESS

Name of Witness (please print)

Signature of Witness

Date