

The Healthy Immigrant Effect in Canada: Understandings of Debility: A  
Literature Review

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### *Note from the Author*

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## Abstract

Immigrants generally start with better-than-average health at the time of their immigrant application and arrival to Canada. This is done through a careful and precise process that rules out disability. Many later faced disabling social determinants of health, such as poor housing, difficulty navigating the education system, precarious working environments, and lack of social support networks. Immigrants are among the most vulnerable members of society, facing xenophobia, judgment, discrimination, and otherness (Dada, 2022). Although it is masked with welcoming faces and implicit suggestions that they are “lucky” to be given a chance to immigrate to Canada and start a new life for themselves. The truth is that once they have immigrated, the journey is incomplete; it is only the start of a new, complex and exhausting journey (Dada, 2022). Most immigrants coming to Canada are here to start families or smaller families looking for new opportunities. Immigrant parents often face challenges adjusting to a new system, supporting their children through school systems that are foreign to them, working to make ends meet and adjusting to a new environment where they are separated and distanced from their families, the majority moving from collectivistic cultures into a more individualistic atmosphere that triggers a culture shock. How are current health policies enough to support the journey post-immigration? What support is available to immigrants, and how can they be better met? From a health policy point of view, many chronic health conditions can be avoided or prevented through health policy implementations and access to healthcare. Immigrants often face language barriers when moving to Canada, and that can impact navigating healthcare settings and school systems. Immigrants are often not aware of mental health and health resources that can be available to them, often leading them to suffer on their own.

## Background:

The *healthy immigrant effect* describes a phenomenon where immigrants exhibit better health than Canadian-born individuals. This effect is not specific to Canada; it has been observed in other countries, including Europe and the United States. However, the health of immigrants significantly declines over the years of residing in Canada. Canada's immigration laws operate on a point system, where applicants gain points based on their "human capital." This means individuals gain points if they are non-disabled and educated. Canada is known globally as a diverse, multicultural country that welcomes immigrants and refugees from all over the world, regardless of nationality, sexual orientation, or religion. It ensures they take pride in their identity (Government of Canada, 1985). Current Prime Minister Justin Trudeau and liberals, in general, have a long history of welcoming others into Canada, stating that there is space and room for everyone (Dada, 2022). Canada is a beacon of hope for thousands of immigrants who come to restart their lives. However, the realities of life in Canada post-immigration involve an uphill battle that includes discrimination, racism, and ableism. Further, the selective process of welcoming immigrants and refugees follows an ableist neoliberal ideology that excludes those with disabilities, as there is a belief that they could potentially strain the resources available for other Canadians (Dada, 2022).

Ableism is defined as a set of beliefs and practices that devalue disability in favour of able-bodiedness. Immigration policies and practices act as a reinforcement of ableist views by further marginalizing people with disabilities. Fiona Campbell argues that "ableism denotes 'an attitude that devalues or differentiates disability through the valuation of able-bodiedness equated to normalcy'" (Paur, 2017, cited in Campbell, 2012). Such attitudes exist in all aspects of society beyond institutions, including cultural and historical contexts (El-Lahib, 2019). Since the

introduction of the excessive demands clause in 1967, Canadian immigration policy has marginalized people with disabilities, excluding them and their families from immigrating if they're perceived to place excessive demand on social and health services in Canada (El-Lahib, 2019). Such policies exacerbate the marginalization of people with disabilities by portraying them as vessels that extract from the economy without giving back to it. This ableist narrative is untrue and perpetuates a broad stigma that affects how people with disabilities navigate their lives, which limits their chances of obtaining the same opportunities and experiences as their able-bodied counterparts.

The selective process of welcoming immigrants also applies to refugees. Refugees are generally seen as a burden on the healthcare system and resources meant for other Canadians. Therefore, the “excessive demands clause” applies to the overall number of refugees and avoids asylum seekers’ arrival. Consequently, immigrants and refugees with disabilities are perceived as an even more significant burden on the Canadian healthcare system, leading them to omit their disabilities during the immigration or refugee application process. An example is the Syrian refugee crisis in 2016 (Dada, 2022). The government of Canada released a statement highlighting the healthcare resources and health safety measures they would undertake while anticipating the arrival of Syrian refugees in 2016. This document included screening refugees for potential contact diseases, health issues, and disabilities (Government of Canada, 2016). In this context, even refugees must construct their identities in a way that seems appealing to the government before being allowed entrance. It is known that Canada may not accept cases considered “severe” - “out of fear, refugees may under-report health issues in the assessment process” (Government of Canada, 2016). Even among refugees, Canada is selective about who can enter and seek refuge. Not all refugees are welcomed; instead, they are assessed on a scale to

determine which bodies would be of more value to Canada and its economy, excluding people with disabilities (Government of Canada, 2016).

## Positionality

I want to emphasize and preface my view that Canada is an excellent alternative for many immigrants to restart their lives, work and prosper. I agree with the idea of a “land of Opportunity.” However, my work mainly emphasizes that with the claim of a land of opportunity, it’s crucial to note that immigrants still require social support to feel situated and ready for life post-immigration. The *healthy immigrant effect* has deep-rooted ableist causes and implicit racist narratives that many immigrants face navigating social services and their new place of living, Canada. I am a first-generation immigrant who came to Canada when I was 7. I have seen first-hand the way that immigrants are treated here. I have helped my parents navigate social services and watched them work hard to get me to where I am currently writing this paper. I have witnessed fellow peers, classmates, and neighbours who have created miniature communities that share information on essential services to access and how to navigate a newcomer's life. These experiences may bias how I view the *healthy immigrant effect*. Therefore, I emphasize that my research has examined statistical evidence and previous theorists who have spoken on these issues.

## History of Relevant Immigration Laws in Canada:

Canada offers several pathways for immigration, including economic class, family class, refugee and humanitarian crises and temporary residents. The Immigration and Refugee Protection Act (IRPA) is a significant part of Immigration Law, containing provisions directly

affecting people with disabilities. The Excessive Demand Clause can deny entry to applicants whose health conditions might place an “excessive demand” on social or health services (Government of Canada, 2001). This provision has been criticized in the past for harming people with disabilities and their families. However, in 2018, the Canadian government revised this policy by altering the criteria for what can pose an excessive demand (Government of Canada, 2018). Immigration laws also offer Humanitarian and Compassionate Considerations where applicants may request consideration on humanitarian grounds, including disability-related circumstances. This provides an exception for cases where strict immigration policies would cause unreasonable decisions related to people with disabilities and their families.

Further, the duty exists to accommodate Canadian human rights laws. However, it does not apply directly to immigration laws; it provides accommodations during the application process, such as accessible communication methods or assistance during medical examinations. Most recently, Canada’s immigration laws have been critiqued by activists and disability studies scholars for including provisions that directly harm people with disabilities. Critical Disability scholars emphasize the importance of continuing advocacy to ensure that immigration policies align with the human rights principles. Some provisions have been altered to limit discrimination against people with disabilities. However, more changes must be made to achieve a more inclusive society.

### Ableism in Immigration Policies:

With the rise in immigration and refugee acceptance in Canada, various ethnicities, cultures, and morals combine in Canada’s cultural melting pot, characteristics many Canadians take pride in. Although the disability justice movement and disability studies have grown, they have not fully considered the intersections of racism and ableism affecting disabled immigrants

and refugees. Recently, critical disability studies scholars have critiqued Canada's immigration system, highlighting the ableist narrative that excludes people with disabilities from entering Canada or getting the same opportunities as their able-bodied counterparts. While Canada is seen as a new opportunity for life, it operates with a neoliberal framework in which everyone must contribute to the economy. Value is given to one's ability to contribute to society, not just take from its resources. Therefore, immigration applicants must prove their worthiness to migrate to Canada.

El-Lahib conducted a critical discourse analysis focusing on two primary sources of data: public CIC (currently termed IRCC) documents, including promotional materials and operational manuals for immigration officers. These documents are meant to facilitate and motivate people to apply for immigration. The second data collection method included interviews with 23 participants, including immigrants with disabilities, families, and social service providers (El-Lahib, 2016). After analyzing this discourse, immigration was found to be constructed in a way that portrays Canada as a land of opportunity "for a better life through which ableist, racist, and colonial discourses are reflected and reinforced by all key players involved in the immigration process from settlement application" (El-Lahib, 2016). Immigrant applicants with disabilities also use this motivational discourse to shape their applications in a way that seems worthy of acceptance. The discourse centers on immigration as an exciting opportunity and a great challenge while underscoring the availability of support systems to help newcomers settle and integrate, suggesting that with the proper preparation, becoming part of Canadian society is achievable only for qualified individuals. Despite these welcoming narratives, Canada disqualifies those who are deemed unfit, such as those with disabilities, insinuating that they are unworthy of accessing these opportunities.

## Intersectionality of Racism and Ableism

Further, responses from interviews showed that immigrant participants often used binary terms of “us” versus “them.” Canada’s immigration narratives usually compare the country favourably to the participant’s country of origin. This comparison highlights Canada as more advanced in human rights, laws, employment, education, health accessibility, and women’s rights (El-Lahib, 2016). These narratives perpetuate a colonial, racist, and ableist discourse that actively suggests Northern superiority compared to the South. This comparison often maintains power divisions between the North and South, primarily through the lens of disability.

Moreover, El-Lahib references Puar’s concept of “pinkwashing,” illustrating how northern countries like Canada portray themselves as superior in terms of queer rights. However, these protections often only apply to individuals who conform to hegemonic heteronormative identities. The reality for people with disabilities, even in Canada, is complex. While Canada can be a land of opportunity for some, immigrants with disabilities still encounter racism and ableism, particularly within social support services, suggesting systemic biases are in place. Although Canada prides itself on being a welcoming nation, these narratives mask the ongoing challenges faced by immigrants, especially those with disabilities, who navigate systemic biases and barriers.

Among other disability studies scholars, Dr. Chavon A. Niles from the University of Toronto wrote “Who Gets In? The Price of Acceptance in Canada,” examining the contradictions in Canada’s immigration policies, particularly how they discriminate against people with disabilities despite the inclusive, multicultural overview they have. Using critical disability studies and critical race theory, Niles conducts a qualitative research study, exploring the stories

of three families who were denied entry or residency due to their disabilities, even if their families were allowed entrance, highlighting a significant flaw in the Canadian immigration system (Niles, 2018). Niles emphasizes the exclusionary practices, case studies, historical context, and impact of policies and pushes for changes to create a truly inclusive country and immigration system (Niles, 2018).

## Case Studies

Niles focused on detailed examinations of specific instances where individuals or families were impacted by Canada's immigration policies due to disabilities. Applicants included Jazmine, Nico, and Harold. Jazmine, a Deaf teenager from the Philippines, was deemed medically inadmissible to join her mother in Canada. Although public outcry led to her acceptance on humanitarian grounds, the government initially deemed her medically inadmissible (Niles, 2018). Nico, a boy with Down syndrome whose family moved to Canada for his father's occupation, was denied permanent residency due to potential future costs associated with Nico's condition. They were later allowed to stay under humanitarian conditions, also prompted by public outcry. Lastly, Harold, an 18-year-old with an intellectual disability, was barred from entering Canada with his mother, who worked in Canada under the live-in caregiver program (Niles, 2018). These specific instances show how people with disabilities were initially denied entry into Canada.

Jazmine, who was a deaf teenager from the Philippines, was initially deemed medically inadmissible based on the excessive demands clause, where disability was seen as posing an excessive demand and burden on public health or social services. Jazmine's situation raised questions about the violation of her rights; in light of Canada's commitments under international

treaties like the United Nations Convention on the Rights of Persons with Disabilities, she claimed that denying her entry based on her disability contradicts Canada's principles of equality and inclusion (Niles, 2018). Public outcry influenced a Humanitarian reconsideration of Jazmine's application. Jazmine stated her disappointment and shock that she would pose an excessive burden on Canada's services when her mother is financially independent and works five jobs, allowing her to support her daughter financially and benefit Canada's economy. Proving the initial ableist opinions of the application is wrong. In addition to Jazmine, Niles provides a case study of Nico, the son of an Ontario university professor and his family, who sought permanent residency in Canada. Nico's family wanted to move to Canada because of his father's career; however, he was deemed medically inadmissible due to his Down Syndrome diagnosis. Nico's family's application was at risk of being denied solely due to Nico's condition. However, after the story gained public media attention through disability activists, Nico's case was reconsidered, and he was allowed entrance into Canada on humanitarian and compassionate grounds (Niles, 2018).

Niles analyzes how disability is socially constructed, arguing that people with disabilities do not have a hard time fitting in; instead, society makes it difficult for them to navigate. Ableist norms often exclude disabled individuals from societal acceptance based on the notion that society must be productive and every individual must contribute to the economy. Moreover, race and disability intersect and lead to discrimination and exclusion (Niles, 2018). From a historical context, Canadian immigration policies have shifted from explicit exclusionary practices targeting racialized and disabled people to more subtle forms of exclusion under current laws. He critiques the current immigration laws, particularly the excessive demand clause that disproportionately affects disabled applicants, reinforcing ableist beliefs. The excessive demands

clause ensures that immigrants coming to Canada do not impose an undue burden on the country's publicly funded health and social services (Government of Canada, 2001). This assessment considers factors such as the severity and perceived cost of the applicant's health condition, medical treatment, and medical expenses.

Niles and El-Lahib have both critiqued the point system under which immigration operates. This point system is ableist, favouring able-bodied, economically productive applicants. It operates on a neoliberal framework that only values individuals who can work and contribute to the economy. Through their research, the authors conclude that discourses from immigration materials include motivational narratives of opportunity, portraying Canada as a haven and land of endless possibilities where people can benefit from prosperous jobs and a welcoming environment. Most importantly, these discourses shape how immigration applicants with disabilities must present themselves, omitting their disabilities to appear more worthy of acceptance for immigration. The authors conclude that to provide genuine opportunities to immigrants, there should be a way for applicants to disclose their disabilities without impacting their chances of acceptance. The notion that people with disabilities will be a drain on Canadian resources is untrue and ableist. Many people with disabilities hold successful jobs when provided with the necessary accommodations. Canada has done an excellent job so far in welcoming immigrants and refugees. Still, as a country actively improving accommodations for disabled individuals, the same effort should be extended to immigrants with disabilities.

## Racism and Immigration

A recent example of a group of refugees who did not face the challenge of proving themselves or fearing rejection on the grounds of disability is the Ukrainian refugees. I

emphasize that refugees from any country fleeing harsh war conditions deserve a place of refuge and shelter. They do not deserve to live in war-torn countries and face unimaginable pain and displacement. Refugees from any country deserve to live somewhere that allows them to carry out their lives and access fundamental human rights, regardless of whether they have a disability. The purpose of this comparison is to highlight the key differences in attitudes and ideologies toward "white" refugees and "brown" refugees. I use quotations around brown and white to mirror how refugees from Ukraine and Syria are described in media and news reports. In reality, not all Ukrainian refugees are white, and not all Syrian refugees are brown, despite how they are represented in media outlets and by the general Canadian public.

The stark differences in attitudes toward Ukrainian refugees and Syrian refugees are critical to highlight in both media outlets and government communications. Amidst the Syrian refugee crisis, Canada announced it would welcome 25,000 Syrian refugees. This was a fantastic act by Canada, intervening to save many refugees from harm's way and letting them know they were welcome. However, it came with the overt expectation that Syrian refugees should be "grateful" (Dada, 2022). This narrative also applied to immigrants, portraying them as saved from an oppressive environment. This saviour-complex narrative suggested that bringing immigrants in was enough and that they were saved from terror and got into a land of opportunity and prosperity. While Canada provides many opportunities to immigrants, the government was not fully equipped to deal with this issue correctly, as immigrants and refugees could not access healthcare and social services (Dada, 2022). Policy changes, such as the 2012 Interim Federal Health Program changes, reduced healthcare services for refugees due to decreased resources available for the general Canadian population (Government of Canada, 2012). This was problematic, as many refugees arrived with physical and mental disabilities

requiring regular healthcare services (Dada, 2022). Disabled refugees are often left out of conversations about access and healthcare.

In contrast, various media outlets in Canada highlighted the gruesome conditions that Ukrainian refugees were fleeing from. Some media commentators, such as Kelly Cobiella from NBC News, Charlie D'Agata from CBC News, and Peter Dobbie from Al Jazeera English, made incredibly racist remarks comparing Ukrainian refugees to Middle Eastern refugees. These comments revealed the implicit and explicit racism and Islamophobia in Canadian news and attitudes. For example, Kelly Cobiella, an NBC News correspondent, stated, "These are not refugees from Syria. These are refugees from neighbouring Ukraine – these are Christians; they're white" (NowThisNews, 2022). Charlie D'Agata remarked, "But this isn't a place, with all due respect, like Iraq or Afghanistan that has seen conflict for years. This is a relatively civilized, relatively European – I have to choose those words carefully too – the city where you wouldn't expect that or hope it is going to happen" (NowThisNews, 2022). Peter Dobbie added, "looking at these are prosperous, middle-class people, they are not obvious refugees that are trying to get away from areas such as the Middle East – they look like any European family that you would live next door to" (NowThisNews, 2022). These comments highlighted the ideological differences in who is deemed deserving of refuge, rooted in racism, Islamophobia, and neoliberalism, where Ukrainian bodies are seen as prosperous and deserving of refuge due to their skin colour and nationality. Although these reporters later apologized for their remarks, the initial damage remains, highlighting the deep-rooted biases in Canadian media and public attitudes.

Additionally, the Canadian government granted Ukrainian refugees work or study permits upon arrival, demonstrating their potential economic contributions. This was not part of the action plan for Syrian refugees, who were often met with skepticism about their ability to integrate and contribute. Both cultures are not primarily English-speaking, but European/white culture was seen as more similar to Canadian culture, making it easier to justify their acceptance. Canada has upheld its promise to welcome all people, but this raises questions about why disabled Syrian refugees were not similarly welcomed.

These biased attitudes were also reflected in the Canadian immigration process. Typically, refugees and immigrants with disabilities are often turned away from Canada due to the perceived strain they might place on the healthcare and welfare system. However, following the Ukrainian refugee crisis, the Government of Canada announced a temporary public policy to “exempt Ukrainian nationals from immigration requirements in support of the Canada-Ukraine authorization of emergency travel” (Government of Canada, 2023). This policy temporarily set aside regular immigration regulations to accommodate Ukrainian refugees, including those with disabilities, without the usual requirement to disclose their disability status. The website also stated that those unable to provide documentation due to their disability could submit electronic documentation (Government of Canada, 2023).

This comparison can be understood within a Eurocentric framework, where European or white ways of thinking and people are regarded as the default (McLennan, 2000). Anything outside this framework is seen as other or criticized. The Canadian media’s response to the conflict in Ukraine revealed their views on Middle Eastern bodies, implying that war in those countries is expected and should not matter. However, the idea that such a war could occur in a

"civilized" country like Ukraine was shocking to them. War is harsh on anyone who experiences it, as we are all human. It is crucial to consider the impact of disability and displacement caused by war and the need for access to resources to treat such disabilities, regardless of whose bodies they belong to. Islamophobia is still prevalent in the ideologies of many in the global North. It is dangerous to equate terrorism with an entire population, as this spreads hysteria and falsehoods. Syrian refugees welcomed into Canada have been grateful for their new lives and wish to work and contribute to a country that provides opportunities despite the discrimination and xenophobia they face. Many articles highlight Syrian refugees' gratitude, providing a humanizing perspective that shows refugees respect and abide by the rules of their new country (CBC News, 2016).

The idea of not welcoming disabled refugees and immigrants is incredibly ableist and should be changed within the immigration application process. The notion that everyone is allowed an opportunity to come to Canada should include people with disabilities, as they, too, deserve a chance. Canada is known for its innovation and prosperity; therefore, providing accommodations for people with disabilities so they may achieve their goals should be the norm. Further, the belief that people with disabilities cannot contribute to society and are a burden on Canada's healthcare system is ableist and untrue. Individuals with disabilities can thrive in working conditions when provided with appropriate resources and accommodations (Jetha et al., 2019). The disability justice movement has long fought for the rights of people with disabilities to work and receive adequate accommodations. To exclude individuals with disabilities from immigration opportunities is ableist and neoliberal. Disability can occur at any point in life due to trauma, accidents, or medical emergencies. It is unfair to prioritize non-disabled individuals in immigration.

Comparing disability with race, the issue of Islamophobia should also be addressed. It should be a national goal to end and limit Islamophobia, as it is incredibly dangerous. It is absurd to equate terrorist acts with an entire group of people based on religion or nationality. The result of Islamophobia can be life-threatening. A recent example is the hate crime against 6-year-old Palestinian-American boy Wadea Al-Fayoum in October 2023. After the Hamas incident on October 7th, their landlord attacked Wadea and his mother when they refused to leave their apartment, ultimately stabbing Wadea 26 times (CNN, 2023). This crime was a direct result of Islamophobia, as the perpetrator equated all Muslims and Arabs with the actions of an extremist group. Another tragic incident was the killing of Ejaz Chaudry, a 62-year-old Muslim-Pakistani man, by police during a wellness check. Ejaz was experiencing a mental health crisis and was shot dead in his home because he could not communicate with the police (Daily Sabah, 2020). This incident highlights how brown bodies are policed and assumed to be a threat.

## Theoretical Framework

This essay adopts a theoretical framework grounded in Critical Race Theory (CRT) and Critical Disability Studies (CDS). CRT offers insights into how racial power dynamics shape social structures and identities. By applying CRT to CDS, this essay aims to uncover how racialized identities intersect with disability in the context of the *healthy immigrant effect*. It will explore how racist and ableist notions in societal institutions and the immigration process contribute to the *Healthy Immigrant Effect* in Canada.

Previously studied by, Sukaina Dada, she has focused on CRT and ableism in her work titled “Stories of Displacement and Disablement Experiences of Syrian Refugees and their Families” (Dada, 2022). Dada summarizes the Syrian refugee crisis, which led to Canada’s

“Operation Syrian Refugees” in November 2015. This operation welcomed 25,000 Syrian refugees over 12 months. Dada emphasizes the importance of narratives and storytelling regarding the Syrian refugee crisis and how it can lead to “critical misunderstandings” when using dominant narratives (Dada, 2022). Specifically, she highlights the stories recorded in newspapers and media outlets. “The dominant narratives about Syrian refugees exist within a realm of ableist, xenophobic, and Islamophobic thinking ... these narratives reiterate problematic images of refugees as terrorists, victims, criminals, and invaders” (Dada, 2022). One critical point is understanding the narratives placed on Syrian refugees, especially following Donald Trump’s comments: “Refugees from Syria are now pouring into our great country. Who knows who they are – some could be ISIS?” (Dada, 2022). Although the U.S. President made this comment, it widely spread through social media, reinforcing the idea that Syrian refugees were potential terror threats to Canada and America.

In contrast, Prime Minister Justin Trudeau publicly welcomed Syrian refugees, stating, “To those fleeing persecution, terror, and war, Canadians will welcome you, regardless of your faith. Diversity is our strength” (Dada, 2022). This narrative positioned Syrian refugees to be eternally grateful to the Canadian government for rescuing them when the neighbouring United States would not. Media outlets such as The Toronto Sun highlighted that Syrian refugees were “taking advantage of social welfare and taking up space reserved for ‘real’ Canadians” (Dada, 2022), causing frustration among Canadians that their tax dollars were aiding refugees. Dada’s analysis highlights the ableist and racist views that were evident in the Canadian public; although it is more implicit, they still hold racist and ableist views.

Justin Trudeau's statement concerning Canada's welcoming of refugees and caring for them did not align well with policy changes. Specifically, the Interim Federal Health Program changes in 2012 reduced primary healthcare access for refugees, disproportionately affecting disabled refugees (Dada, 2022). One aspect often unnoticed in narratives about Syrian refugees is the trauma that refugees and immigrants carry from experiencing war and displacement. Many refugees feel gratitude for escaping war but mourn the loss of their homeland and the culture shock of adapting to a new country. Many face disablement, whether physical or mental and without adequate resources to support their condition, mere welcoming is not enough. The dominant narratives suggest that providing a place to stay is enough, leaving the rest of the journey up to the refugees to figure out, yet they should be grateful because they're better off.

Dada provides an example of an elementary school principal describing a Syrian refugee student as "disruptive and noncompliant" because he hides under the desk and blocks his ears when the bell rings. She follows this statement: "I know what you're going to say. He came from a war-torn country, but how long will we use that as an excuse?" (Dada, 2022). This narrative shows the ableist mindset of this principal, expecting the refugee child to get over his traumatic experiences and be grateful for his new life. Dada uses Critical Disability Studies and Critical Disability Studies to understand how refugees were treated in Canada, a fundamental theory for this essay. Refugees were treated with racism and ableism not just through the refugee application process but also by politicians and media articles that spread dominant narratives about them before getting a chance to experience them or understand what they have gone through. These narratives speak to Canadians' feelings about "others" seeking refuge in "their" country.

Further, Rachel Di Silveira Gorman theorizes the intersections of antiracist and anticolonial community organizing, focusing on ‘race’ and ‘disability’ in their article “Disablement in and For Itself: Towards a ‘Global’ Idea of Disability” (Gorman, 2016). Their work explores disability studies through antiracist and anticolonial perspectives, transnational feminist theory, critical institutional ethnography, and Marxist dialectics. Gorman critiques mainstream disability studies for focusing predominantly on white, Western-centric narratives and calls for an inclusive approach centring on the lived experiences of disabled Black, Indigenous, and People of Color (BIPOC) (Gorman, 2016). One foundational pillar of the essay is its antiracist and anticolonial stance. Gorman highlights the need to address the specific realities of disabled BIPOC in Toronto and transnational spaces (Gorman, 2016). This approach challenges the dominance of white-focused narratives within disability studies and emphasizes integrating racial and colonial contexts to understand disability fully. The essay adopts a transnational feminist framework, drawing from Chandra Mohanty’s historical materialist analysis. This perspective examines disability within global capitalism, neo-colonialism, and patriarchal nationalism, expanding disability studies beyond local and national boundaries (Gorman, 2016). It addresses socio-economic exploitation and cultural marginalization intersecting with disability globally.

Gorman’s essay employs critical institutional ethnography to critique how institutional practices and state policies marginalize disabled BIPOC. This methodological approach reveals the systemic nature of disability oppression and the role of institutions in perpetuating colonial and racial hierarchies. Gorman delves into concepts of necropolitics and biopolitics to analyze how disability is constructed politically and socially. They argue that disability identities can be both a site of rights and a marker of vulnerability, revealing deeper structures of racial violence

and exclusion. The essay challenges existing paradigms within disability studies, advocating for a more inclusive and critical approach that centers BIPOC perspectives and critiques colonial and capitalist structures.

An essential fundamental understanding in Gorman's work is the discussion of eugenics and race. Gorman claims that eugenics is often the foundational narrative of disability oppression in US-based disability studies. This narrative is grounded in racial and colonial violence and is frequently overlooked. Gorman argues that it is too narrow to address the full spectrum of violence and marginalization experienced by racialized and colonized disabled populations (Gorman, 2016). Historically, eugenics advocated for the "improvement" of humanity through selective breeding, significantly influencing and perpetuating disability oppression narratives. In the United States, eugenics policies led to the forced sterilization of many disabled people and others deemed "unfit" (Gorman, 2016). Disability studies have documented and critiqued these practices, highlighting the dehumanizing impact of eugenic ideologies on disabled individuals. However, this eugenics movement often centers on the experiences of white-disabled individuals and overlooks how eugenics intersected with and was reinforced by racial and colonial ideologies. For example, sterilization programs in the US disproportionately targeted Black, Indigenous, and Latinx populations. Gorman highlights that mainstream disability studies often fail to engage with how eugenics was used as a tool of racial and colonial control, contributing to broader systems of oppression for people of colour (Gorman, 2016).

By critiquing the eugenics-focused narrative, Gorman calls for a more inclusive and comprehensive approach to disability studies that addresses the intersections of race, colonialism, and global capitalism. Gorman calls for decolonizing disability studies, unpacking

how colonial histories and contemporary practices shape the lived experiences of disabled people globally, especially those from marginalized racial and ethnic backgrounds. They advocate applying global perspectives, recognizing that disabled people's experiences worldwide are influenced by diverse historical, cultural, and socio-political contexts (Gorman, 2016). Through a more accurate and holistic understanding of disability within a global context, we can better advise policy (Gorman, 2016). This approach helps address the root causes of disablement, including systemic racism, economic exploitation, and colonial legacies, rather than focusing solely on individual rights, which overlooks root causes and creates band-aid performative policies. Through Gorman's understanding of working towards a more holistic understanding of disablement, the *healthy immigrant effect* can be understood more deeply, allowing for accurate and effective policies.

Lastly, an important paper relevant to understanding the *healthy immigrant effect* from a CDS lens is Jasbir Puar's "The Right to Maim: Debility, Capacity, Disability." Puar offers a profound critique of how states use debility and disability as tools of biopolitical control. Puar introduces "debility" to describe the condition of bodies made to endure ongoing harm and precarity, distinct from disability and capacity (Puar, 2017). This framework challenges traditional disability studies by emphasizing the intersectionality of race, gender, and geopolitics in producing bodily harm. Puar argues that states exercise power through direct violence or withholding care and the deliberate infliction of debility (Puar, 2017). Puar provides a specific example of this form of control in the context of the Israeli occupation of Palestine, where the state creates conditions of life that lead to chronic injury and incapacitation (Puar, 2017). Puar's analysis extends beyond this specific geopolitical context, suggesting that debility is a global phenomenon used by states to manage and control marginalized populations.

Another essential term coined by Jaspir Paur in their *Right to Maim* is “Spacio-suicide, whereby terrain is dependent on the withdrawn colonizer’s infrastructural support, modulates calories, megawatts, water, telecommunication networks and spectrum and bandwidth allocation to provide the bare minimum for survival” (Paur, 2017). Paur situates this term in the colonial violence seen against the Palestinians by the Israel Defence Forces (IDF), being justified through victim ideology and through the excuse that they are “not killing people.” Historically, Israel did not exist until May 16<sup>th</sup>, 1948. Following the first Nakba (catastrophe) of 1948, thousands of Palestinians were displaced from their land and fled to the Arab parts of Palestine, which include Gaza, Jaffa, Nazareth and Nablus. Thousands fled to neighbouring Arab countries such as Jordan and Egypt for refuge. As Puar mentions in her book, Gaza, although not under the direct rule of the Israel state, is still controlled by IDF. Gaza is described as an open-air prison, controlled at all exit and entrance points by IDF soldiers (Puar, 2017). Even before the 2023-2024 Israeli war on Gaza, IDF soldiers controlled the caloric intake of food and water sent into the Gaza Strip and the electricity that runs inside; therefore, the population has been under *de facto* Israeli control. In this case, it is not the physical act of death itself, but “death itself is literalized as the slowing down of Palestinian life” (Paur, 2017).

As Puar describes in *Right to Maim*, Israel complies with the “Right to not kill” by maiming/hurting Palestinian civilians. The IDF has been known to use machinery that is known to cause long-term pain in its victims as well as aiming for target points such as the knees, elbows or head, in a way that does not kill the individual but ensures that they live in pain (Paur, 2017). The IDF claims that the violence carried out against the Palestinians is self-defence against protesters. However, as mentioned in the book, in November 1988, protests in Gaza were at their lowest, while casualties were still at an all-time high, thereby “contesting the claim that

the IDF is only responding to violent activity” (Puar, 2017). Therefore, killings and what Puar calls *debility*, or what Gorman calls *disablement*, in both contexts are carried out by the colonial state. Although there might not be direct killings in every situation, there are direct state-sanctioned actions that lead to frailty, disablement, and often a slow death. Violence and harm can be directly inflicted on a nation by its colonial-settler state, or it can be done implicitly by justifying violent acts and neglect and letting them exist (Puar, 2017).

Moreover, the theoretical foundation of Puar's work is deeply rooted in biopolitics, a concept derived from Michel Foucault, which examines the strategies and mechanisms through which human life processes are managed under regimes of authority over knowledge, power, and subjectivity. Puar expands on this by incorporating Achille Mbembe's concept of necropolitics, focusing on using social and political power to dictate how some people may live and how some must die. By combining these frameworks, Puar demonstrates how producing debility operates as a form of slow violence that sustains inequality and oppression (Puar, 2017). Puar's critique of disability studies is notable for its insistence on accounting for the uneven distribution of debility along the lines of race, gender, and sexuality, where people of colour or marginalized communities are further marginalized through uneven distributions of debility. She argues that traditional disability frameworks often fail to consider how state-sanctioned violence and neglect disproportionately affect marginalized communities, limiting the potential for a genuinely intersectional understanding of disability.

Puar employs biopolitics and necropolitics to elucidate how populations are differentially managed and exploited. Biopolitics refers to the strategies and mechanisms through which life is regulated and managed, often through inclusion and support for specific groups. Necropolitics

involves the deliberate exposure of populations to injury, death, and debilitation as a means of control and domination. In this framework, disability rights and inclusion in the global north can be seen as a biopolitical strategy to manage and incorporate disabled individuals within a neoliberal order, masking the systemic production of debilitation elsewhere (Puar, 2017). Meanwhile, the global south is subjected to necropolitical strategies where populations are left to endure chronic states of debility without adequate support or recognition that further debilitate and marginalize them. Puar's work is instrumental in rethinking disability not merely as a matter of rights and inclusion but as profoundly entangled with geopolitical forces and state strategies. Her concept of “the right to maim” highlights how states can exert control by allowing specific populations to persist in perpetual debility, thereby maintaining hierarchical social orders. This perspective urges a reevaluation of disability within the broader context of global power dynamics, emphasizing the need to address the structural conditions that produce debility. The theoretical implications of Puar's work call for a critical reassessment of how disability is conceptualized and addressed within policy and advocacy, emphasizing the necessity of considering the global and intersectional dimensions of bodily harm and resilience. This lens is essential for understanding the *healthy immigrant effect* and expanding how race and ableism play into the concept.

Critical Race Theory is an interdisciplinary and intersectional framework that recognizes racism embedded in society's social fabric and institutions. It focuses on how different systems of oppression intersect and shape individual experiences. Niles, Gorman, and Puar have all used these frameworks in their work, and they relate to understanding the declining health status of immigrants in Canada. CRT rejects the additive approach to oppression and stresses the importance of understanding how various forms of discrimination overlap and intersect. This

perspective is crucial for examining the interplay between race and disability, which has historically been underexplored in Critical Disability Studies. CRT scholars use counter-narratives to challenge dominant ideologies and highlight the lived experiences of marginalized groups.

Further Critical Disability Studies is an interdisciplinary approach that critiques how society constructs and responds to disability. It posits that disability is not an inherent limitation but a social relationship shaped by the interaction of bodily differences and societal norms. This theory highlights how capitalist societies prioritize able-bodied norms and marginalize those who deviate from these standards. According to Campbell (2009), ableism is a network of beliefs and practices that produce a "corporeal standard," which casts disability as a diminished state of being. This framework emphasizes that societal structures, rather than individual impairments, create disadvantages for disabled people by valuing productivity and physical normalcy, especially in the context of industrial and post-industrial capitalism.

## Limitations

With the focus on Critical Disability Studies and Critical Race Theory, some limitations come from applying these theoretical frameworks alone. I recognize these limitations and assumptions and will go through them in detail. Some theorists claim that CDS provides an overemphasis on social construction by sometimes underplaying the significance of biological and medical aspects of disability, which are crucial to understanding the full scope of disabled individuals' experiences. Further, Carol Thomas in "Sociologies of Disability and Illness" (2007), as well as Fiona Kumari Campbell in "Contours of Ableism: The Production of Disability and Ableness" (2009), critique CDS for being focused on theoretical discourses at the

expense of developing practical applications. Campbell argues that this can sometimes lead to a disconnect between academic discussions and the real-world challenges faced by disabled people (Campbell, 2009). However, as I acknowledge the limitations of using any theoretical frameworks, I emphasize the portion of my thesis that will point to policymakers regarding the next steps. I recognize that the *healthy immigrant effect* has been present for years and is a focus topic for health policy specialists. However, it's important to dissect and analyze this issue from a Critical Disability Studies perspective and a Critical Race Theory that looks at the limitations that societal structures impose on immigrants in Canada. Policies are challenging to understand without understanding the full societal implications that exist. How will policymakers fully understand how to take on this issue without understanding the societal implications? Therefore, I believe this work will be necessary as a stepping stone that can aid in driving policy implementations in the right direction.

Moreover, some limitations and critiques of Critical Race Theory exist, such as potential polarization, which can make others resist such theories or receive backlash from those who feel attacked. Further, CRT can be focused on the Black-White dichotomy, which can marginalize the experiences of other racial and ethnic groups. Some theorists claim that while Critical Race Theory provides powerful critiques and long-term visions for societal transformation, it may not always offer clear, immediate strategies for addressing racial inequalities in everyday contexts (CNN, 2021). Some politicians have publicly critiqued CRT. Donald Trump stated, "Students in our universities are inundated with critical race theory. This is a Marxist doctrine holding that America is a wicked and racist nation, that even young children are complicit in oppression, and that our entire society must be radically transformed" (CNN, 2021). While I recognize that there are limitations to using this theoretical framework, like many others, this theory holds immense

importance in understanding the disparities immigrants face over the years of living in Canada due to how social support services, healthcare facilities or the law treat them. My objective is not to prove that Canada is a “wicked nation” but to shed light on the issues that immigrants face, which may be overlooked. Rather than causing any limitations or marginalizing other ethnic groups, a thorough understanding of the *healthy immigrant effect* through a Critical Race Theory will bring society closer to creating more holistic policy improvements to better the health of the immigrant population. Further, it will educate the public more clearly about the racist circumstances that many immigrants face.

## Immigrant Health in Canada: Cardiovascular Disease, Diabetes, and Stroke

Immigrant health in Canada faces significant challenges, particularly in the areas of cardiovascular disease (CVD), diabetes, and stroke. Initially, new immigrants arrive with lower rates of CVD, including hypertension and heart diseases, compared to the Canadian-born population. However, this health advantage diminishes over time, typically within the first decade of residence. Main cardiovascular diseases include coronary artery disease, hypertension, and heart failure. This essay has three main health issues: cardiovascular diseases, Diabetes and stroke. New immigrants typically arrive with lower rates of cardiovascular diseases (CVD), including hypertension and heart diseases, compared to the Canadian-born population (Qazi et al., 2015). Main cardiovascular diseases that exist include Coronary Artery Diseases, Hypertension, and heart failure. Over time, however, their risk of developing such conditions increases due to lifestyle changes, stress and reduced physical activity. This advantage that immigrants hold in having healthier cardiovascular health diminishes following the initial years post-immigration, precisely over ten years.

Cardiovascular disease is a common health issue that is seen in the immigrant population later on in life. Cardiovascular disease is categorized by disease in the heart and blood vessels, which causes chest pain, shortness of breath, coughing/wheezing, uneven blood supply to extremities and fast/uneven palpitations (World Health Organisation, 2017). Cardiovascular disease is stated to be caused by tobacco use, alcohol abuse, increased blood pressure or hypertension. Some articles that specify the importance of social determinants of health emphasize the structural and cultural barriers that may lead immigrants to develop serious issues such as CVD. Stress is a social contributor to cardiovascular disease as well. Patients who struggle with CVD for prolonged periods without medical intervention or knowledge of the condition can face sudden death by heart attack if not caught and monitored early.

Diabetes, similar to CVD, shows a lower initial prevalence in immigrants. Upon arrival, most immigrants, particularly those from non-western countries, show lower rates of diabetes through the initial health exams conducted before immigration. However, rates of diabetes tend to rise with the length of residence in Canada. Factors contributing to this increase are changes in diet, reduced physical activity, stress related to social integration and socioeconomic status. Some literature emphasizes social determinants of health and states that health and disability are influenced by social, economic, and political factors rather than solely influenced by biological predispositions. Diabetes is influenced by income and social status. Social assistance and food insecurity were independently associated with lower health-related quality of life. Having precarious work impacts the ability to have healthier food habits and consume nutrient-dense foods. Some literature claims that education is also a key determinant, with higher levels of education being linked to a better health-related quality of life, which immigrants often have (Maddigan et al., 2005).

The perceived health status and perceived mental well-being of long-term immigrants are significantly lower than that of other Canadian counterparts. A common condition experienced by immigrants that worsens over the course of their lives in Canada is depression. Similar to the previous two conditions mentioned, new immigrants experience lower rates of depression compared to their Canadian-born population. They experience an initial excitement of moving and starting life in a new country and gaining better opportunities. However, after being faced with some harsh realities, over time, this prevalence of depression increased significantly (CBC, 2023). Hyman and other authors have associated this increase in levels of depression with social isolation, discrimination, and the stress of adapting to a new environment (Hyman, 2001). Social isolation is felt and experienced by immigrants at the same rate throughout their stay in Canada; the initial feelings of isolation experienced by immigrants when they first arise do not diminish over time; instead, they stay the same.

Lastly, strokes are a prevalent health issue experienced by the immigrant population in Canada. The risk factors of stroke, according to medical journals, are obesity, physical inactivity, heavy or binge drinking, and use of illegal drinking. Further, the medical risk factors include high blood pressure, high cholesterol, diabetes, cardiovascular disease and family history. Race and ethnicity are also a contributor to a higher risk of stroke; research shows that African American or Hispanic people have a higher risk of stroke compared to other races/ethnicities in the United States. The literature on this decline highlights dietary changes, stress, socioeconomic challenges, and lack of healthcare access. Articles have mentioned that immigrants may gradually adopt Western dietary patterns that are different from what they are used to, often higher in fats, sugar, and processed foods, which are patterns that can eventually lead to weight gain, higher cholesterol, and increased blood pressure, all of which are risk factors that may

contribute to a higher risk of CVD, diabetes and stroke. Specifically, a study by Ng and Omariba (2011) found that recent immigrants had lower rates of hypertension than other Canadians; however, this advantage decreased significantly after ten years of residency. Hypertension is categorized as prolonged high blood pressure, which is often increased with prolonged stress.

## Healthy Immigrant Effect in Canada: CVD, Diabetes, Stroke and Depression

It is a consensus among disability studies theorists that disability is socially constructed and perpetuated by society. It is not an individual who is limited by their disability as much as it is a society that limits their potential through lack of accommodation and implicit neglect. The reality of the *healthy immigrant effect* is that immigrants go through a rigorous and time-consuming process to meet immigration guidelines. The main component includes proving their worth to the Canadian government for immigration. Immigrants view Canada as a land of opportunities and prosperity that may differ from the opportunities they will get in their home countries; therefore, they try to omit any characteristics that may deem them unfit to immigrate (El-Lahib, 2019). The Canadian government sets These characteristics and standards, such as being fit, healthy, free of any concerning health conditions and having a good educational background (Government of Canada, 2024). Immigration is one of Canada's main strategies for economic growth. More than half of recent immigrants admitted to Canada are based on economic category (Government of Canada, 2024). "Immigrants admitted under the economic category are selected based upon their potential economic contribution to meet labour market needs, or to create economic opportunities by owning, operating or investing in a business or through self-employment" (Government of Canada, 2024). It is in the interest of the Canadian economy to let in the most prosperous and promising immigrants in the hope that they will work and give back to the economy. However, this glorious idea that all will be well once immigrants

have made it through and settled down in Canada is untrue, as immigration is only the first step of a long and challenging journey.

The most common health concern that immigrants are struggling with is cardiovascular disease. This includes heart attacks and heart failure. Although, as mentioned earlier, these health concerns were not present during the immigration process, they are seen as a significant decline after years of residing in Canada. The National Library of Medicine (NIH) states that major cardiovascular events are 30% lower in recent immigrants compared to long-term residents in Canada. South Asians are reported to have a higher incidence of acute myocardial infarctions (MI) compared to their white Canadian counterparts (Sabastian et al., 2022). The NIH claims that the top risk factors include smoking, high blood pressure, type II diabetes and high cholesterol levels. South Asians have a higher cardiovascular risk due to dietary patterns, physical inactivity and resistance to lifestyle changes (Sebastian et al.,2022). The NIH also states that knowledge about CVD risk factors is generally low among immigrants, especially those who do not speak English fluently as well as access to healthcare and routine screening for chronic conditions like diabetes and hypertension is low among immigrants.

Of course, hypertension, poor diet and other biological determinants can put people at a higher risk of developing cardiovascular disease. However, we must wonder what social determinants drive this decline as well. Immigrants face tremendous stress when navigating a new life, mainly when they need more resources to help them navigate. A Mental Health Research Canada study showed that new immigrants are almost twice as likely to be concerned about feeding their families than those born in Canada. Mental Health Research of Canada has analyzed how newcomers face challenges accessing services, precisely 11% compared to 4% of

non-newcomers. Immigrants face food insecurity and housing insecurity. Within 2-5 years of living in Canada, 39% indicate house-related anxiety as compared to 22% of non-newcomers. Immigrants are isolated from their support systems, which they have left back home to come to Canada (Sebastian et al.,2022). These factors make a complicated way of living, putting increased stress over a long period on immigrants to make ends meet. Normal levels of stress are expected and something many people live with, including immigrants and non-immigrants. However, increased chronic stress is a contributor to long-term heart problems, including increased heart rate and high blood pressure, all of which can put people at risk of hypertension. It is no surprise, then, that immigrants hold the highest rates of hypertension in Canada.

Another disease that is most common among long-term immigrants in Canada is diabetes. There are two types of diabetes: type 1 and type 2. Type 2 diabetes is non-preventable; however, type 2 is, and that is the one with the highest prevalence in the immigrant population. Currently, long-term visible minority immigrants are about 2.3 times more likely than their white-Canadian born to have and develop type-2 diabetes. A study conducted in 2019 called “Revisiting the *healthy immigrant effect* with diabetes risk in Canada: Why race/ethnicity Matters analyzed the difference in diabetes prevalence in visible-minority long-term residents in Canada versus white-Canadian counterparts. There was a significant difference between the two, and the authors concluded that it was due to several factors. Firstly, social factors such as lower income and precarious work lead to limited access to healthy food, safe neighbourhoods and safer neighbourhoods for physical activity and health (Adjei et al., 2019). Further, cultural barriers exist, including language barriers and lack of familiarity with the healthcare system, which can prevent immigrants from seeking medical help and health-seeking behaviours.

Lastly, strokes are most common in long-term immigrants compared to recent newcomers. Long-term residents are referred to as those who have been living in Canada for more than ten years compared to those who have lived in Canada for less than ten years. The same trend of seemingly healthy immigrants sees a decline in their health, and the risk of stroke has increased after ten years of residing in Canada. Current literature has accounted for this based on similar factors to diabetes and heart disease. That includes cultural factors, lack of social support, and difficulty accessing preventative healthcare services. There are biomedical markers for increased risk of stroke, such as genetic predisposition and early signs of potential stroke occurrence. However, those biomedical markers increase and become more apparent with the influence of environmental factors. Genetic biomarkers are difficult to avoid, so a patient will be more aware of the signs and seek help. However, the social influences of stroke are modifiable and, therefore, can be preventable through education and policy reforms for newcomers.

### Healthy Immigrant Effect and Debility:

The declining health of immigrants in Canada should indicate the realities of living in Canada. Sudden life-threatening health conditions such as heart disease, stroke and diabetes have indicators that appear earlier on in one's life and are present for years without the person knowing. They are preventable and treatable if caught at an early stage. However, in Canada, the rates of these diseases are significantly higher in the immigrant population, specifically long-term immigrants, as opposed to newcomers. Moreover, chronic diseases such as hypertension and depression are a widespread occurrence among the immigrant population; this comes with the challenges of navigating a new life in a foreign country. Many immigrants have pre-existing

stigma about mental health issues such as stress and depression; it is often seen as a normal part of life, which can cause them not to seek out professional help. However, doctors should be aware of this difficulty and cultural barrier to understand how to deal with immigrant patients. Physicians should be able to educate patients on their health and how to manage it. Not doing so, whether it is because doctors are not taking the time to inform immigrants or because newcomers cannot access health services, is violence inflicted on them through neglect. The reality is that immigrants become debilitated over the years of living in Canada because of the system that neglects them under the guise of creating a welcoming country for them.

Research also shows that self-assessments of immigrants report that lower perceived wellness is greater the longer they live in Canada (Athari, 2020). This overall perceived state of health includes mental health as well. In specific, white immigrants report 35% higher perceived health as compared to immigrants of colour (McAlpine, 2022). This is a common theme in Canada's immigrant status. Although immigrants, no matter where they come from, are experiencing a new environment and navigating foreign health and social services. The difference between the reported health of white immigrants and immigrants of a visible minority is alarmingly different. This raises questions about why. Immigrants of colour and Canadians of colour in general face racist and discriminative treatment in schools, workplaces, public service sectors, public transit or even just on the street. Some BIPOCs in Canada have tried to work on eliminating their accent to speak like everyone else in order not to get discriminated against (CBC, 2019). Some BIPOC have reported adjusting the way they carry themselves and speak in public so that they are not looked at oddly, such as not being too loud and reluctance to share ideas with passion; a participant in an article produced by CBC News said, "It exhausting... the

anxiety sets in. The fear of saying the wrong thing. You find yourself speaking less, and holding yourself back” (CBC, 2019)

Managing stress is an umbrella term used by patients and the public through advertisements, government websites, and health promotional websites (Government of Canada). Currently, the government of Canada has a page on their website titled “Mitigating the impact of stress” that highlights mindfulness and how to exercise it. However, that is the same thing as putting a band-aid on a gaping wound. How are immigrants required to “mitigate stress” when they are experiencing precarious work and discrimination in healthcare and social service sectors while maintaining a living and paying their bills? The truth is that all the statistics are readily available and prove that immigrants are one of the most neglected demographics in Canada. Although health issues do not arise until later in life, they are present and have occurred for years. Why is that not a priority for the government? Suppose Canada truly is the land of opportunities that welcomes everyone and wants them to succeed, the government. In that case, specifically, the health sector should make a difference in newcomers' healthcare access. Canada is more of an individualistic society; however, many of its immigrants come from collectivistic societies where everyone helps everyone. Culture shock alone should be accounted for, and newcomers should be provided extra guidance.

According to Dada, immigrants and refugees are constantly treated with a dominant narrative that exists within the realm of ablest, xenophobic and Islamophobia thinking. These narratives take up space and transfer how Canadians feel about immigrants or anyone coming to Canada as the “other.” Dada’s work is based on the experience of Syrian refugees after the Syrian war. From personal experience, many Canadians are ignorant of the difference between

refugees and immigrants and, therefore, group everyone under the same umbrella of being the “other.” Immigrants, although come from multiple countries across the globe, they face stigma and are grouped under specific categories based on their appearance or the colour of their skin. I distinctly recall a conversation I overheard my parents have when we first came to Canada, which was a few weeks after the September 9th, 2001, incident of the Twin Towers in the United States, which Canada and The United States have noticed a spike in Islamophobia. My parents spoke of their anxieties from the attitudes they would get from Canadians in any social setting. My dad, being a tall brown man with a beard and moustache, was very susceptible to Islamophobic harassment. My mom, however, did not receive the same scrutiny as she is fairer and did not wear a hijab at the time; she looked “white.” People assumed my father was a refugee and did not care to understand his qualifications or how hard he had worked to immigrate to Canada. The 9/11 incident was a contributing factor to the dominant narrative that exists when referring to immigrants of colour.

Instances like these experienced by the family are a perfect example of Edward Saïd’s concept of Orientalism, whereby the West constructs and represents the “Orient” as the ultimate “other” (Edward Saïd, 1978). These constructs of the “Orient” often refer to any countries east of Europe, generally Middle Eastern countries. Saïd emphasized how this construct is not an objective reality; instead, it is a Western invention that maintains hegemony over the Orient through politics, culture and intellect, thus reinforcing Western superiority. These images of the Orient often put its people in a light that perceives them as savage, undereducated, needing saving by the West and, thus, inferior to the West (Saïd, 1978). Unfortunately, the West used these representations as a tool to dominate and control the region; since they were reinforced through culture and media, many generations grew up believing this depiction of the truth. In this

situation, some people my family have come across had a particular belief about Middle Eastern-looking individuals as being “lazy” or belonging to a specific group. Due to the negative portrayals of my people, my family had stereotypes made up about them before even experiencing them or conversing. This is a result of the harm of Orientalism and these dominant narratives.

These dominant narratives also affect the likelihood of immigrants accessing health services. For example, a study at Windsor University by Grace Pollock noted the experience of immigrants trying to find a family doctor; one participant called an office to ask for an appointment, and the receptionist asked, “Are you an immigrant?” The patient responded with, “Yes,” to which the receptionist answered, “The doctor does not have space” (Pollock et al., 2019). This attitude towards this immigrant patient exists among many doctors. Many participants from this study were turned away because offices viewed them as “too time-consuming, emotionally overwrought, or exceptionally demanding” (Pollock et al., 2019). The staff at certain doctors’ offices also act as gatekeepers to the system. Another participant in the Windsor study, James, a Black male, arrived at a walk-in clinic when he forgot his health card at home; he was treated with suspicion and told to go home and get his health card before seeing the doctor, whereas another white female patient was let in to see the doctor even though she also forgot her health card. This racism exists, and although not explicitly shown to the patients, it is implicit and affects the patient’s willingness to re-access such services. Many immigrants feel discriminated against, unwanted and ambushed by the services meant to help (Pollock et al., 2019). This leaves them unwilling to re-access these services even though they are freely available under the Universal Health Act.

The research that currently exists on stroke, diabetes or CVD provides band-aid solutions for people to manage their health in a better way by exercising, eating better and managing stress. These are great ways to live and sound medical advice to patients. However, these solutions do not account for the impact that social disparities have on the likelihood of disabilities. Further, they blamed the patients themselves for not living a healthy lifestyle that would later develop into health issues. Medical information is knowledge, and in the context of newcomers in Canada, that knowledge may not be more readily available and understandable. For the rest of Canadians, medical information is readily available online. People can research certain diseases and symptoms to understand their feelings and whether they require medical attention. However, immigrants who experience language barriers may face difficulty accessing medical information and healthcare practitioners. Immigrants also need help accessing information on specific governmental processes and ways to navigate essential steps such as buying a house, filing taxes, how to use a credit card, what a credit score means and what it does.

Policy specialists should aim to gain a more holistic understanding of the development and occurrence of declining health in the immigrant population in the context of the *healthy immigrant effect*. Immigrants face declining health over an incredibly short period, which is concerning and should be regarded as a significant health emergency that should gain the attention of policy advisors and healthcare workers. It is cruel to let the healthiest, most educated people into a country that will only make them sicker over the years through neglect of their health and discrimination in the workplace. Meanwhile, Canadian society pushes the narrative that they are better off and should consider themselves lucky to have had the opportunity to immigrate to Canada. Socio-political factors contribute to the declining health of immigrants. Political standards are not adjusting, nor are they providing services that are crucially needed.

Further, social contexts such as neglect and discrimination in healthcare settings and government agencies all contributed to feelings of loneliness and depression (CBC, 2023).

Currently, members of certain immigrant groups have resorted to creating their miniature communities with the help of Facebook or other community organizing initiatives. For example, my own family are first-generation immigrants; my mother is part of an Egyptian association group on Facebook where members share important informative posts about finding a doctor, learning to file taxes, available housing for newcomers, doctors who speak the same language as them so that there are no language barriers present. This initiative was started by a group of Egyptians who realized the difficulty of navigating life in Canada and the importance of being around like-minded individuals who share the same struggle and are willing to help (Facebook, 2024). Not provincial or federal governments organized a group for newcomers to share important information; the struggling members took that initiative due to the complex realities of living in Canada and the need to find solutions to help each other. This group is relatively new, and my parents needed access to it upon their arrival here. Now, with the help of this Facebook group, they have learned more about Canadian politics and have found members of their community who have impacted their mental health in a good way. I know that if this group had been available for them when they both first arrived in Canada, it would have had a better impact on their mental health and the way they navigate their life in Canada.

Social constraints exist that limit marginalized populations, such as immigrants, from partaking in these practices. The literature puts the blame and the responsibility on the patient, giving advice that is challenging to follow, especially considering the economic difficulties many immigrants face. “Debility,” described by Paur, is something that immigrants face daily in

Canada, evident by their declining health over the years. The government of Canada directly exercises its power by withholding care and culturally sensitive intervention that is accessible to immigrants. The government takes rigorous interventions when deciding which immigrants to let into the country to ensure their resources will not be exploited or drained. However, once the immigrants are here, they are left to figure out how to navigate the structures by themselves, which is incredibly difficult. There are many things immigrants must learn how to do by themselves, such as find housing, find a job, learn how to apply for a job in Canada, apply for a credit card, understand the importance of a credit score, find schooling for their children and ensure that their kids are receiving proper education in and outside of the classroom. All while holding a steady job, paying bills, and facing discrimination in public situations. Since no social support is available, they must hunt these services down, or they may not be aware that such resources are even present. Although this pattern of neglect does not appear to be an act of violence at first glance, when examined carefully, it is a utilization of necropolitics practiced through neglect. This is apparent through the uneven occurrence of debility in long-term immigrants compared to newcomers. Moreover, it is apparent through the uneven occurrence of debility in immigrants of colour compared to white immigrants in Canada.

The interconnected play of factors that contribute to the declining health of immigrants can be understood within the idea of biopower by Micheal Foucault. This idea discussed by Puar also refers to the practice of modern states and their regulation of their citizens through “an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations” (Foucault cited by Puar, 2017)—this form of power operations on individualistic, collective, and regulating levels. In the context of the *healthy immigrant effect*, the individualistic level would be the doctors and public sector workers, the collectivistic level

would be the general attitudes towards immigrants and the stigma they carry, and the regulating level would be the government laws, regulations and lack of intervention with the immigrant population. This questions what contributing factors lead to the stigma and general attitudes towards immigrants in Canada. Factors such as news reports, movies, and shows have come together to shape a way of understanding and referring to immigrants. Scientists have studied the correlation between negative media portrayals of certain ethnic groups and the bodily response evoked by them. The study called “Negative media portrayals of immigrants increase ingroup favouritism and hostile physiological and emotional reactions” whereby participants were shown media representations of specific demographics with different colour skin and perceived minority status. They were to associate particular characteristics to each group. The study found that preferable characteristics such as altruism were associated with the participant's native group compared to traits like untrustworthiness compared to foreign groups (Becchetti et al., 2016).

Further exists the idea of immigrants being “better off” or “lucky” to be in Canada. Dominant narratives have also portrayed the home countries of immigrants as barbaric and corrupt; therefore, moving to a country like Canada is a grand upgrade for them (Dada, 2022). This narrative often dismisses that although Canada is efficient and has progressed in its human rights and universal healthcare, significant discrepancies exist in such systems. For example, a considerable shortage of family doctors is available to Canadians. Although there is free healthcare access in Ontario, not everyone can access a primary healthcare practitioner. Across the province, 2.3 million people do not have access to a family doctor, and the Ontario College of Family Physicians warns that this number could grow to 4.4 million patients by 2026. In the past year, there have been 103 unclaimed spots of family medicine practices (CBC, 2024). This is because many medical students complete their practices in family doctors’ offices, where they

see how stressful the workload is and how underfunded family doctors are; therefore, they choose not to specialize in it. The issue with family care practices is that they are underfunded and under-supported, which leaves fewer medical students wanting to specialize in family medicine. This, in turn, has created a shortage of family doctors in the province.

This shortage, coupled with the growing population in Ontario, increased immigration, and refugees, is creating an uneven distribution of resources. Family doctors can only take on a certain number of patients at a time, and most family practices have waitlists for new patients. If people cannot access family practices, they are faced with a difficult journey to access mental health services or obtain medical attention for pressing health concerns. It may take some people years to see a family care practitioner, which can exacerbate their condition. This is true for new Canadians trying to find a family practitioner. The interdisciplinary issue includes many driving forces that must be adjusted and improved. All these are possible reasons for decreasing health statuses. The underfunding of the healthcare sector is another way that the state inflicts violence on its inhabitants. Although not direct and explicit, failure to support and fund an industry meant to help citizens and improve their health leads to people needing to be educated on health measures and health-seeking behaviour. Further, it leads to medical issues going unnoticed for years, which can harm one's health.

The *healthy immigrant effect* is fed and exacerbated by the societal conditions that immigrants must overcome and navigate. The disablement of immigrants is rooted in racist and ableist understandings of “productiveness” and individualism. As mentioned earlier, Canada is a very individualistic society, whereby people are expected to seek resources depending on their needs. Resources include legal help, help navigating government procedures (i.e. filing taxes),

and personal needs (i.e. medical help or finding housing) for many Canadians living in Canada for years who have support from their families and experience navigating specific systems. Immigrants, on the other hand, often do not have these support systems in place and frequently feel isolation and loneliness. According to Canada's government, self-perceived loneliness is a crucial indicator of general well-being. There is an identical level of self-reported loneliness between recent and long-term immigrants. This suggests that such feelings do not dissipate over time but remain the same. It is common for many immigrants not to feel like they are “home” despite living here for years; they often feel like an “other” despite their citizenship status being Canadian.

Declining health in the immigrant population and declining self-perceived health are often seen later in a person's life, precisely over 40 or after ten years of living in Canada, which feelings of isolation can exacerbate. There are various contributors to feelings of isolation in immigrants, including barriers and challenges that exist, including language barriers, lack of culturally appropriate services and dependency on other family members for translation. This is an instance I have noticed in my own family. Being a first-generation immigrant, I have seen my parents struggle in situations with healthcare workers and government representatives through many procedures. I noticed the difference in the attitudes of healthcare workers when I accompanied my parents as a 10-year-old new immigrant who spoke with an accent and did not understand English well compared to the current attitude we are greeted with. I am now a 24-year-old woman; I speak without an accent and appear white-passing if alone. I have accompanied my parents on various appointments and government visits for essential processes. My parents first noticed the seamless way procedures are carried out when I am present versus when I am not. For example, doctors take their time more with my parents when I am there to

translate and ask questions; however, when they are alone, they are rushed out, and concerns are quickly brushed over/dismissed.

Moreover, we have had various comments about how “assimilated” or “educated” I am, which suddenly gives value to my family. Without it, my parents are discriminated against and given odd looks. Thus, over the years, although my parents have not explicitly said it has negatively impacted their mental health, they do not feel genuinely at home, although they have lived here for about 20 years. Such feelings of isolation can cause many immigrants to feel hesitant when accessing various services if they do not have family members to accompany or help them like my parents did. This calls into question how they navigate such systems independently; some may opt not to seek help, and some may seek out help and get discriminated against, which can evoke feelings of reluctance not to seek help again.

Policy advisors have called for reforms in the way that immigrants can combat feelings of loneliness. The solution is not very straightforward as the capitalist neoliberal society we live in has many layers that contribute to this decline in health and feelings of loneliness even if one lives in a country for over ten years. Many factors are at play, including how immigrants are viewed depending on their origins, the lack of health services available, and the difficulty they face integrating into a new society. Immigrants face language and cultural barriers that the government is well aware of but does nothing about. Why is it okay and accepted when immigrants meet the immigration standards, but, in turn, the government does not equip them for the realities of navigating life in Canada? Navigating life in Canada is difficult enough for Canadians who have lived here for years and whose families have lived here for years; the reality of immigrants is exacerbated when language and cultural barriers are combined into the pot.

Similarly, the term coined “spacious suicide” by Jasbir Puar, immigrants live in an imaginary bubble that isolates them from the “rest.” This bubble is present when exercising or navigating social services and daily life (Puar, 2017).

The struggles of the immigrant population, specifically in the context of debility, are a difficult thing to understand when the dominant way of thinking and understanding debility and disablement is a white-focussed narrative. Similarly to Gorman’s discussion of critiquing mainstream disability studies for its predominant focus on white, wester-centric narratives, there exists a need for understanding and investigating the experience of debility in the context of BIPOC, such as the immigrant population in Canada. To fully understand the realities of the immigrant population, we must go beyond a simple neoliberal framework where we believe all is well once someone is working a stable job and that one’s ability to reach that job speaks to one’s value in society. The neoliberal society that has been organized and actualized is pushing marginalized individuals deeper into difficulty and hardship without a lending hand from policy advisors, policymakers and the public. Disability is produced through our system and further exacerbated through neglect, lack of intervention, and inadequate resources.

### Case Study:

Illnesses such as stroke, diabetes, or cardiovascular diseases can leave a person debilitated for life, unable to continue their lives the way they once did, unable to continue working, or face job loss, which further marginalizes them or causes them to face homelessness. For example, Amir Farsoud, a 54-year-old immigrant man from Iran living with a severe disability who was working before his disability, is currently relying on government payments for life expenses. He was not able to make ends meet and afford a living. He reached a point

where he was worried he would be unable to afford a residence after the place he resided in went up for sale. Farsoud applied for Medical Assistance in Dying (MAiD) in Canada because he thought he would not be able to survive being homeless; his rationale was “wanting to die a dignified death” (Marcus, 2019). After these events, a GoFundMe account was opened, and the community raised \$60,000 for Amir (Marcus, 2019). Amir was later able to afford a new residence and able to pay for his daily expenses. He said, “People like me don’t want extravagant lifestyles; we just want to move on” (Marcus, 2019). Amir also stated that he knows many other people facing the same issues and struggling to make ends meet with Ontario’s Disability Support Payments of \$1,200 a month.

This is one of many cases that has been publicized, and Amir Farsoud is one of the few individuals who were fortunate to have his case publicized to strangers who were kind enough to help his condition. The reality is that not everyone has faced the same fate and had heroes supporting their cause. Further, why is it up to civilians to take matters into their own hands and save people from the impact of disabling government policy? It was due to the community that Farsoud’s case became public, and he could reach hundreds of individuals who continued to share his story and share the GoFundMe link that brought on the donations. After Farsoud became financially stable and had access to a home, he withdrew his application for MAiD. Although he was still severely disabled, he wanted to continue living his life since he had shelter and could afford food and his medications. That is all this person requires to want to live again and not exercise MAiD. In the context of Farsoud, he was living alone, without a family, as he immigrated to Canada alone. After years of living alone and working in Canada, still, when he was debilitated; he found himself unable to keep up with the cost of living. He received disability cheques that were insufficient to cover his move to a new residence. Although Farsoud’s

condition may not have developed necessarily through the HIE or due to social limitations, he was an immigrant who faced isolation throughout his years of living in Canada and almost ended up being homeless due to the systemic barriers he faced. Farsoud would rather exercise MAiD than face precarious housing and the dangers of living on the street. What is more heartbreaking is that his application for Medically Assisted Suicide would have been accepted had he not received the support he needed.

Drawing on Gorman's recommendations for more effective policy and advocacy efforts, there is a deep need for a broader understanding of disability that I hope this paper can shed light on. Issues such as cardiovascular disease, stroke and disability are not simply avoidable through exercise and good eating habits; those are mere biomedical suggestions to limit the chance of gaining these illnesses. Instead, there are deep-rooted stigma, racism, and islamophobia that are present in the way Canadians understand immigrants. Such harmful narratives are present daily through social media, news articles, or government figures. Although these views have decreased over the years, and, in general, more Canadians accept immigration or refugees, there still exists an old and deep-rooted stigma that cannot simply disappear overnight. It involves multiple layers of unwrapping stigma and implicit biases when interacting with immigrants.

### Recommendations:

Through understanding the intersections of ableism, critical race theory, immigration, and the *healthy immigrant effect*, it becomes more evident that structural and systemic factors significantly influence health outcomes among marginalized populations. Although not explicitly visible, ableism and racism implicitly exist in systemic structures that come with difficulties for immigrants in Canada. Ableism and racism intersect with health disparities experienced by

immigrants, particularly in the context of chronic diseases such as diabetes, stroke, and cardiovascular disease (CVD). The *healthy immigrant effect*, where immigrants initially show better health outcomes than Canadian-born individuals, often dissipates over time due to the combination of stressors such as discrimination, socioeconomic challenges, and limited access to healthcare services. Immigrants and other Canadians are usually advised to limit their stress levels to promote better overall health. However, providing solutions such as “reducing stress,” which are impossible to implement at the individual level, underscores the importance of unravelling the multiple layers of discrimination that affect immigrant health. Eliminating or limiting the level of stress that immigrants face is not a simple solution because many immigrants cannot avoid stress. It comes through precarious work placements, which can lead to food insecurity, discrimination in health or social services or feelings of isolation. Unfortunately, these issues are at every level of Canada's systems and, therefore, complex to avoid, especially when providing Band-Aid solutions. By examining how systemic racism and ableism shape health policies and practices, we can better understand the barriers to equitable healthcare access and the social determinants of health that disproportionately impact immigrant communities.

A comprehensive approach that includes policy reform, community engagement, and culturally competent healthcare practices is required to address these disparities. Recognizing the unique experiences of immigrants and the specific health risks they face can inform targeted interventions and support services. Since this is a systemic issue, more specific interventions are required at every level of the systems immigrants face. Starting from the immigration application itself, the excessive demand clause should be eliminated. It perpetuates a harmful ableist narrative that is not only untrue but further marginalizes people with disabilities. The idea that people with disabilities are a strain on the economy is untrue, as we have seen people excel in

environments where their accommodations are met. People with disabilities acquire jobs, have families and can thrive in environments where they are not constantly discouraged because they have a disability.

Further, there is a dire need for culturally sensitive healthcare services for immigrants. Being culturally sensitive in this situation means understanding the different cultural backgrounds of immigrants and ensuring a thorough understanding of what medical conditions are most common among immigrants. Most medical issues are preventable if patients are educated on better health-seeking behaviours, appropriate diets and early screenings. For example, many people may not be aware that increased blood pressure over a long period may lead to cardiovascular issues. Therefore, if medical professionals properly educate them, they can take medicine to lower their blood pressure and be sure to screen for heart issues if they experience any symptoms early. It is general knowledge that immigrants' health deteriorates over time, and this has been prevalent for years. Therefore, active failure to accommodate immigrants and ensure their health remains stable across their residing time in Canada is a form of debilitating neglect. Due to this, it would be beneficial to provide certain or all medical professionals with cultural competency training that can be state-mandated. Since Canada is incredibly multicultural, practicing physicians must be culturally competent. However, some doctors may not opt into this training due to a lack of time or support, so physicians need more government support to make this possible. Fostering a more inclusive and equitable healthcare system will involve breaking down the barriers perpetuating health disparities and embracing a holistic understanding of health that acknowledges the intersection of social, economic, and cultural factors.

Further, social integration and social support are essential interventions to provide better support for new immigrants. Many immigrants may need help with language barriers that make integrating into their new environment challenging. Therefore, government funding that goes into allowing immigrants to enter Canada should also provide social support services where immigrants can be incorporated into their communities by building connections. This can be a way to mitigate social isolation that can develop into depression and anxiety in newcomers. Having a social circle and support contributes to good mental health and well-being. Therefore, for immigrants who mainly come from collectivistic cultures into a more individualistic culture, social integration positively affects their mental well-being. Through this, they can gain more information about navigating life in their new residence and ultimately better support their families.

## Conclusion:

The projection of immigrant health in Canada shows a significant difference in initial and long-term well-being. Immigrants often arrive with lower rates of cardiovascular disease, diabetes, and stroke compared to their Canadian-born counterparts. However, the *healthy immigrant effect* declines significantly over time due to lifestyle changes, socioeconomic stressors, and systemic barriers. As immigrants reside in Canada for a prolonged amount of time, they encounter many challenges, including shifts in diet, reduced physical activity, and increased stressors, contributing to a deterioration in their health status. Cardiovascular diseases, diabetes, and strokes become increasingly prevalent among immigrants, particularly those who have resided in Canada for over a decade. The initial health advantage quickly diminishes by the effects of social determinants such as income inequality, precarious employment, and

discrimination. These factors lead to higher incidences of hypertension, type 2 diabetes, and stroke, which is often exacerbated by the difficulty in accessing culturally appropriate healthcare and support services.

Furthermore, Puar's concept of "debility" can help in understanding immigrants' declining health, as it is not merely a consequence of personal choices but a reflection of systemic neglect and socio-political inequities. The Canadian healthcare system, while overtly inclusive, often fails to address the unique needs of immigrants, particularly those from visible minority backgrounds. The disparities in perceived health and access to care between white immigrants and immigrants of colour call into question the effectiveness of health policy initiatives. Addressing these health disparities requires a multi-faceted approach that goes beyond medical interventions. It involves acknowledging and addressing the socio-economic and cultural barriers influencing immigrants' access to health resources and services. The Canadian government and healthcare systems must recognize and act upon the socio-political dimensions of immigrant health, ensuring that support structures are in place to mitigate the effects of the immigrant experience.

The growing strain on healthcare resources, coupled with increasing immigration and population pressures, results in an uneven distribution of medical services and neglectful interactions with patients. The inability to access family doctors and mental health services can lead to prolonged wait times and exacerbated health conditions. For many immigrants, especially those who have lived in Canada for a decade or more, these systemic disparities contribute to worsening health outcomes. Moreover, the intersection of ableism and racism in Canada's healthcare system further complicates this issue. Immigrants encounter discrimination, neglect,

and language barriers, which impair their access to necessary services and exacerbate feelings of isolation and loneliness. The experiences of individuals like Amir Farsoud highlight the profound impact of inadequate support and the failure of both healthcare and social systems to address the needs of disabled immigrants adequately.

Understanding disparities requires a comprehensive approach that goes beyond superficial band-aid solutions. Effective policy reform must address the root causes of health inequities, including the need for culturally competent healthcare, improved social integration, and the elimination of ableist narratives that occupy health and social services. By fostering a more inclusive healthcare system and providing adequate support for immigrants, Canada can better support the well-being of its newcomers. Addressing the systemic barriers that contribute to the decline in immigrant health is crucial for creating a more equitable and supportive environment. This involves reforming healthcare policies and challenging the societal attitudes and structures instrumental in perpetuating harmful narratives. By doing so, Canada can move towards a more equitable healthcare system that genuinely supports the well-being of all its residents, reflecting its commitment to being a land of opportunity for everyone.

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