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# An Excessive Demand: Immigrants with Disabilities and Medical Admissability in Canada's Immigration System

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**AN EXCESSIVE DEMAND: IMMIGRANTS WITH DISABILITIES AND MEDICAL  
ADMISSABILITY IN CANADA'S IMMIGRATION SYSTEM**

by

Anna Penner, BSc, University of Toronto, 2005

A Major Research Paper  
presented to Ryerson University

in partial fulfillment of the requirements for the degree of

Master of Arts  
in the Program of  
Immigration and Settlement Studies

Toronto, Ontario, Canada, 2012

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# **AN EXCESSIVE DEMAND: IMMIGRANTS WITH DISABILITIES AND MEDICAL ADMISSABILITY IN CANADA'S IMMIGRATION SYSTEM**

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Master of Arts  
Immigration and Settlement Studies  
Ryerson University

## **ABSTRACT**

This paper explores barriers to immigration and settlement for people with disabilities attempting migration to Canada. Existing literature on immigration and disability in Canada supplements the stories of three immigrant women with disabilities who shared their experiences of immigration and settlement in loosely structured interviews. This paper draws upon a critical disability studies perspective to emphasize the ways in which immigration policies and practices limit access, particularly the excessive demands provision of the Immigrant and Refugee Protection Act (IRPA). A gendered analysis is employed to recognize the specific experiences of women with disabilities immigrating to Canada.

This paper finds that the barriers faced by immigrants with disabilities extend beyond the excessive demands provision into other policies and practices that fail to address the intersection of disability and immigration status, and that immigrants with disabilities develop alternative approaches and resistive strategies in navigating their lives during and post-migration.

*Key words:* immigrants; disability; immigrant women; policy

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## **Introduction**

Canada has worked to develop itself as a country that supports, and is supported by migration. Indeed, the current Citizenship and Immigration Canada website advertises this history proudly, reading: “Since 1869, Canada’s immigration programs have helped build a community of citizens respected around the world” (Citizenship and Immigration Canada: About Us, 2011). Unfortunately, this history of migration has been accompanied by a history of exclusion, in which certain groups of immigrants have been categorized as undesirable. People with disabilities have frequently found themselves among those excluded from migration to Canada and still experience exclusion in current policies and practices. In 2001 the Immigration and Refugee Protection Act came into effect, replacing the 1985 Immigration Act. Section 38(1) of the new Immigration and Refugee act reads, “A foreign national is inadmissible on health grounds if their health condition (a) is likely to be a danger to public health; (b) is likely to be a danger to public safety; or (c) might reasonably be expected to cause excessive demand on health or social services.” (Immigration and Refugee Protection Act). The language mirrors section 19(1) of the earlier Act, adding only an exception allowing entry to spouses and children of Canadian citizens and permanent residents. The third category of exclusion is commonly referred to as the “excessive demands” provision and has been cited by immigration officials when denying permanent status to immigrants with disabilities (Mosoff, 1998). An estimate by a Citizenship and Immigration Canada spokesperson suggests that 0.2% of all immigration applications are denied based on this provision (Wallace, 2011).

The excessive demands provision is only the most recent manifestation of a history of exclusion levelled against people with disabilities who attempt migration to Canada (Mosoff, 1998). While the provision emphasizes the burden people with disabilities could place on social services, the exclusion of people with disabilities in Canadian immigration policy was instituted before these services were largely developed, and reflects a broader conception by the Canadian state of people with disabilities as undesirables. Both Section 38(1) of the Immigration and Refugee Protection Act and the assumptions behind it have a direct impact on the lives of people with disabilities navigating the immigration system because applicants are scrutinized as to whether or not their lives and bodies pose an excessive demand. This research project focuses on the experiences of people with disabilities who have immigrated to Canada, and uses their

stories to reflect on the ways in which disability is understood and negotiated in the processes of immigration and settlement. I employ a critical disability approach to explore the ways in which policies such as the excessive demands provision, and the practices that accompany these policies, can serve to limit access for immigrants with disabilities. While acknowledging the barriers that are constructed in the policies and practices of migration, this research also emphasizes the strategies of resistance and resilience demonstrated by immigrants with disabilities in negotiating migration and settlement.

### **Disability and Demand- Writing on Immigrants with Disabilities in Canada**

#### *Disability and Canada's Immigration Policy, Then and Now*

Post-Confederation, “immigration policy was regarded as one of the cornerstones upon which the new nation would develop” (Kelley and Trebilcock, 2000; 13). While early immigration policies were largely geared towards attracting a large number of immigrants to Canada, later policies became increasingly focussed on admitting only the most able or desirable of immigrants into the country. The 1906 Immigration Act, for instance, allowed Cabinet to categorically bar any type of immigrant they felt would hinder the nation’s development (Kelley & Trebilcock, 2000, p. 15). In addition to the shifting categories of exclusion that this Act permitted, “the insane, the epileptic, deaf and dumb, blind and infirm” (Kelley and Trebilcock, 2000, p. 136) were summarily excluded. By the Immigration Act of 1976, the characteristics of the ideal immigrant were no longer explicitly defined by ‘race’ or ethnicity as they had been in earlier policies; however, the desirability of an immigrant based on ability remained. Over a hundred years later, the exclusion of people with disabilities found in the 1906 Immigration Act is still present in Section 38(1) of the Immigration and Refugee Protection Act (IRPA)<sup>1</sup>.

Section 38(1) of the IRPA is put into practice through the medical examination which all prospective permanent migrants are required to undergo. The doctors who perform the examinations, all of whom have been approved by Citizenship and Immigration Canada, are instructed to categorize the applicant’s health as belonging to one of three groups: “Findings that

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<sup>1</sup> The Act reads: “A foreign national is inadmissible on health grounds if their health condition (a) is likely to be a danger to public health; (b) is likely to be a danger to public safety; or (c) might reasonably be expected to cause excessive demand on health or social services” (Immigration and Refugee Protection Act).

are unremarkable or minor conditions which normally respond well to short term outpatient treatment”, “Findings that require periodic specialist follow-up care but which normally can be handled without resorting to repeated hospitalizations or the provision of social services”, or “Findings that may require more extensive investigation or care”. The medical form goes on to describe the types of conditions that might warrant inclusion in the latter category, including “dementia”, “mental retardation”, “developmental delay requiring special educational/training”, “psychiatric disorders causing clinically significant distress or impairment in social, occupational, or other important areas of functioning”, “functional impairment due to strokes, etc.”, “multiple sclerosis”, and “genetic/inherited disorders likely to create a functional deficit”. In addition to these stated examples, medical practitioners may make their own assumptions around the investigation or care necessitated by a given condition. The clear barriers to migration for people with disabilities created by these conditions has been confirmed through the court challenges and public appeals made by individuals denied residency on the basis of their disability or the disability of family members (Chadha, 2005; Council of Canadians with Disabilities, 2009).

#### *Disability and the Excessive Demands Provision*

Despite a history of policies and practices excluding immigrants with disabilities, little academic research has taken place on the impact of the excessive demands provision on immigrants with disabilities, or on similar legislation in other countries (Abrecht et al, 2009). The literature on the topic is primarily non-academic in nature, produced by individuals and advocacy groups either in anticipation of or in response to court cases and legislative changes (Chadha, 2005; Council of Canadians with Disabilities, 2009). Individual applications denied under the excessive demands provision have occasionally garnered media attention (Keung, 2011; Wallace, 2011) but these reports focus on the individual circumstances of the applicant, and have not developed into a broader analysis of the legislation itself. This was evident in June, when two articles were published by the Toronto Star within a week, highlighting the cases of two families whose immigration applications had been denied under the excessive demands provision, based on a child’s autism. The articles noted that 0.2% of immigration applications were denied under the excessive demands provision, and quoted a Citizenship and Immigration spokesperson’s explanation that this was based on long term cost to health and social services,

but did not delve into a deeper examination of how these costs were assessed or understood. Instead, both articles focussed on the individual family's cases. One article discussed the case of an American family whose son with an autism spectrum disorder is considered "high-functioning" (Keung, 2011). Community members and friends of the family were quoted, emphasizing the boy's "potential to contribute" (ibid.). The other article described a family from China, who have been living in Canada on temporary permits since 2003. The child's ability or potential to contribute was not focussed on in this article, he is described as autistic and non-verbal, and instead the worth of the family is emphasized. The MLA of Moncton East, where the family resides, is quoted, explaining of the family: "They've been contributing to the New Brunswick economy, they are proud members of the community and their [non-disabled] son wants to be dentist." (Wallace, 2011). To date, the newspaper has not expanded upon these articles or challenged the appropriateness of the legislation that produced these cases. While responses to legislative challenges and media coverage of individual cases do provide insight into the impact of the excessive demands provision, they remain confined to the stories and situations they describe. Attention must also be given to others denied by the excessive demands provision and to the legislation itself, including disability in research and academic discussions on immigration policies and practices.

### *Race and Migration in Disability Studies*

While there has been little writing on disability in the field of immigration and settlement, disability studies literature has included little discussion of intersections between disability, race and migration. Shildrick and Price (1998) note that while debate around disability is "properly concerned with the social response to corporeal difference, it is frequently insensitive to other differences such as gender, sexuality and ethnicity" (226). Dossa (2009) offers a parallel critique of feminist studies, where "the subject of race remains unaddressed" (21). In conducting a literature review on the intersections of disability with other identity markers, Stienstra (2003) identifies that "much more research is needed to develop our understanding of the different perspectives and inequalities people of colour with disabilities face, immigrants with disabilities face and aboriginal people with disabilities face" (p. 21). Dossa (2009) more specifically draws attention to a missing analysis around race and racialized bodies in disability literature, explaining that "the social invisibility of immigrants who have disabilities

is reflected in scholarship. The growing literature on disabilities barely makes reference to the life situations of racialized persons” (4). Dossa suggests that the most effective response to the current invisibility of immigrant women with disabilities in both feminist and disability scholarship is to utilize an intersectional or “pluralistic” approach that recognizes the complex interactions of multiple identities and forms of oppression (ibid.; 156). In discussing the intersections of racism and ableism experienced by immigrants with disabilities when accessing social services, El-Lahib and Wehbi (2011) utilize an anti-oppressive model, similarly focussing their analysis recognizing intersectionality. Though this paper examines the particular relationship between disability status and migration to Canada, other aspects of participants’ identities, including race and ethnicity, have also informed their experiences of migration and settlement. Where possible, I have attempted to recognize these intersections. Anti-oppressive or intersectional analyses also offer tools for further research and discussion and have the potential to increase visibility and understanding of people who are marginalized on multiple fronts.

### *Models of Disability*

The small body of academic literature acknowledging the intersection between migration and disability has been largely critical of the excessive demands provision (Iyioha, 2008; Mosoff, 1998; Stienstra, 2003), identifying it either as a failure of Canada’s obligations in the field of human rights (Iyioha, 2008), or as upholding a medical model of disability. The medical model of disability frames disability as a medical condition or disease, a “physical or bodily lack—as inability, incapacity, deprivation, deviation from the normal” (Shildrick & Price, 1998: 227). Individuals with disabilities are understood as requiring treatment or a cure in order to achieve normalcy and live full and meaningful lives (Shildrick & Price, 1998; Llewellynand & Hogan, 2000). Within this model, an individual’s ability to “overcome” disability determines their success and is often seen as a result of their willpower or courage (Llewellynand & Hogan, 2000) and individuals unable or unwilling to overcome disability are viewed as both deviant and dangerous, and as a permanent burden or threat to their families, communities and countries. This model is reflected in the assumption that an individual’s “health condition” could pose an excessive demand to Canada’s health and social services. At the same time, this model ignores the ways in which individuals who have not been pathologized or labelled as ill might also

access, or place demand on, these services. The medical model of disability presents people with disabilities as being fundamentally impaired, in what Dossa (2009) refers to as “a disease paradigm of defect and abnormality” (43). It fails to take into account the social and financial contributions the individual may offer to Canada and fails, as well, to consider the human rights of the individual (Mosoff, 1998, Stienstra, 2003). Dossa adds, “introduce the elements of race and gender (negative differences) into this paradigm, and you have the makings of even further dehumanization” (ibid).

The medical model has been heavily criticized by people in the disability rights movement and by the academic field of critical disability studies and, alternatively, several other methods of conceptualizing disability are being offered. Disability theorist Eli Clare (1999) challenges the medical model when he asks the questions: “where does our inability lie? Are our bodies like stalled cars? Or does disability live in the social and physical environment, in the stairs that have no accompanying ramp?”(67) The social model of disability challenges the conception of disability as a wholly physical deficiency imbedded within the person who experiences it. This approach is consistent with an anti-oppression framework, through which “people with disabilities are seen to face barriers to inclusion in society not because of their own individual ‘deficits’ or impairments, but because of their belonging to a minority social group in a society shaped by power relations” (El-Lahib & Wehbi, 2011; 4). The social model’s challenge to the conception of disability as deficiency is also shared by feminist disability studies, which denaturalizes disability as deficiency (Garland-Thompson, 2005). Instead of approaching disability as a manifestation of disease or weakness, feminist disability studies and the social model identify the ways in which physical, social and legal conditions develop that accommodate only a particular normalized body. In addition to being non-disabled, this normalized body is dominant in regards to identity markers such as race, gender and class. These critiques of the medical model emphasize that bodies that exist outside this construction of normal are made deviant and denied access in spaces, practices and policies that are themselves “disabling” (Clare, 1999; Llewellynand & Hogan, 2000; Garland-Thompson, 2005; Dossa, 2005; Dossa, 2009). The social model views disability not as a distinct physical or mental category but rather, as Garland-Thompson (2005) explains, “disability—similar to race and gender—is a system of representation that marks bodies as subordinate, rather than an essential property of

bodies that supposedly have something wrong with them” (1157-1158). Researchers working from a feminist disability studies standpoint or utilizing a social model of disability have argued that the medical model places the responsibility for overcoming disability on the individual and distracts from issues and policies that limit possibilities for people with disabilities. Feminist disability studies and the social model recognize that people with disabilities are “oppressed by a society obsessed with concepts of normality” (Llewellynand & Hogan, 2000; 160).

The dominance of the medical model and the inclusion of a medical exam in the process of acquiring residency requires that a person with a disability “overcome” disability and display worth and ability in a way that is recognizable and understandable to his or her presumably non-disabled assessor. The understanding that a person with a disability must meet or exceed an ableist understanding of function or success facilitates the creation of the “supercrip” (Clare, 1999). As Clare notes, “supercrip stories never focus on the conditions that make it so difficult ... I don’t mean medical conditions. I mean material, social, legal conditions. I mean lack of access, lack of employment, lack of education, lack of personal attendant services. I mean stereotypes and attitudes. I mean oppression. The dominant story about disability should be about ableism” (2). The presence of the excessive demands provision-- with its threat of denied access— demands that immigrants with disabilities consider and present themselves in relation to the established criteria of ability.

While the social model allows for a refocusing on policies such as the excessive demands provision, recently it has been argued that it does not create an adequate understanding of disability. Some clinical practitioners argue that an exclusive focus on disabling policies and practices denies actual differences in physical or cognitive ability (Llewellynand & Hogan, 2000). Simultaneously, disability theorists have suggested that using the social model of disability to argue for increased rights maintains a binary distinction between normal and abnormal (Shildrick & Price; 1998) and that refocusing attention from people with disabilities to inhibiting policies and practices has occurred in a way that denies physical difference, or what Shildrick and Price (1998) call “the bodiliness of being-in-the-world” (229). Finally, the social model positions people with disabilities as unresponsive or inanimate objects, unto which ableist policies and practices are imposed. It does not account for individuals’ experiences of these policies or practices, or for their reactions or resistance. In reality individuals are active

participants in their own lives with individual experiences and reactions to broadly imposed prejudice and discrimination (Dossa, 2009). Speaking of an immigrant woman's experiences of the healthcare system Dossa (2009) writes: "the failure by the system to recognize Sara as a person with aspirations resulted in her being rendered an object with only a stigmatized identity of a racialized person with disabilities" (135). Exclusive reliance on the social model of disability risks doing the same. Despite these critiques, disability theorists have generally recognized the valuable shifts in attitude and policy that the social model of disability has facilitated. As Shildrick and Price (1998) have acknowledged: "there have been clear and positive changes both in attitudes towards those with disabilities, and in the expectations that disabled people may themselves hold" (225). The social model of disability is useful in that it allows for the refocusing of attention towards the excessive demands provision itself and away from the assumed deficiencies of the people who are denied migration through it. This research project will focus on policies and away from disability itself, in line with the social model of disability. The focus on participants' physical, mental and emotional experiences of migration under the excessive demands provision recognizes bodily experiences of disability and inaccessibility, but does not identify these experiences as an inevitable consequence of disability. While I identify the excessive demands provision as disabling policy, in line with the social model of disability, it is useful to acknowledge and incorporate the critiques of this model and to recognize the lives and bodies of people with disabilities without denying difference. In the following discussion of the cost-benefit analysis applied in Canada's immigration system and the impact of this analysis on migration and settlement, I utilize the social model to convey how policies and practices limit access. I have also included discussion of resistance, recognizing that individuals actively respond to the barriers that are imposed on their bodies and lives.

### *Immigrants with Disabilities and a Cost-Benefit Analysis*

Though the excessive demands provision does not apply to refugee claimants in Canada, and no longer applies to spouses and children of Canadian permanent residents and citizens, it denies permanent residence to those independent applicants whose disabilities have been used in assessing them as an excessive demand to Canada's social services (Iyioha, 2008). The routes of migration that remain available to those applicants who have been denied on the basis of disability, or to those who feel that their disability prevents them from applying for permanent

status, include temporary residence permits or irregular migration. While a 2001 Supreme Court challenge resulted in instructions to visa officers to consider the individual immigrant's situation and resources before applying the excessive demands provision, Iyioha (2008) argues that the criteria still levelled against immigrants constitutes a failure to meet Canada's human rights obligations, as it remains fundamentally restrictive and exclusionary.

Despite the Supreme Court's instructions, applicants' chances of acquiring permanent residence may still be negatively impacted by systemic assumptions about disability. In her theoretical review of the excessive demands provision, Mosoff cites the example of an immigrant who was assessed as unemployable based on disability, despite the individual having had an extensive employment history. As noted by Dossa (2005), this assessment relies on the "market-based" orientation of Canada's immigration system and "erroneously dismisses [immigrant women with disabilities] as non-productive and dependent" (p. 2528). This erroneous dismissal is grounded in the medical model of disability and doubly disadvantages people with disabilities when assessing their skill and worth as potential immigrants to Canada. The assumption that people with disabilities are ill or weak simultaneously dismisses their potential contributions to Canada's economy or social systems or workforce while emphasizing the cost they will pose to these systems. In the cost-benefit analysis of immigration applications, immigrants with disabilities are disadvantaged by ableist assumptions of both their cost and value. El-Lahib & Wehbi (2011) provide a neat summary of how the economic focus of Canada's immigration system negatively impacts immigrants with disabilities:

"people with disabilities are not seen as potential contributors to the economic life of Canada, they are less likely to be considered preferred applicants. People with disabilities are assumed to be too costly to be granted entry as they are seen to be an economic burden on medical and social services systems" (4)

Garland-Thomson (2005) links an economic justification for excluding people with disabilities, as manifest through the excessive demands provision, to the economic exclusion of women. She explains, "an ethos of economic efficiency used to strip disabled people of access to resources and privilege echoes feminist explications of gender inequities embedded in American liberal ideologies" (1578). Also included in this "ethos of economic efficiency" are the established criteria for assessing immigration applications to Canada. Routes of legal migration to Canada,

outside refugee claims and family class applications, assess the potential market-based value of the applicant. The general practice of using a market-based assessment of an immigrant's worth, as well as the ableist assumption that immigrants with disabilities have little to offer to the market, make up another dimension of the excessive demands provision.

### *Difficulties Connected to Migration without Permanent Status*

As previously noted, the number of immigration applications denied based on the excessive demands provision has been estimated at 0.2% of the overall total of applications (Wallace, 2011). This percentage does not reflect the number of people who choose not to apply, based on the fear or knowledge that they will be denied based on disability. It is likely that many individuals within these excluded categories are unable or unwilling to live in Canada without the possibility of permanent status. Others might make the decision to migrate without status or as temporary residents without access to Canada's full range of health and social services. Unfortunately, the exact number of individuals with disabilities migrating under these conditions in Canada remains unknown: Canada does not keep statistics on the number of irregular migrants in the country and little research has been done on the subject (Bernhard et al, 2007; Sandys, 1998). There is also no Canadian data on the race, ethnicity or migration history of people with disabilities in Canada (Stienstra, 2003). This failure by the Canadian government to keep data on applicants is compounded by the conditions of temporary or irregular migration into which some of these prospective immigrants enter. As noted by Albrecht and his colleagues in a study of Iranian immigrants with disabilities in Belgium, migrants "may have only the passport of the country from which they came, provisional papers or no papers at all and they may be illegal residents seeking asylum or just trying to survive off the radar screen" (Albrecht et al, 2009; p. 260). As a result, a majority of the research available on immigrants with disabilities and the excessive demands provision is theoretical in nature and very little research has been done that explores the quantitative effects or the qualitative experiences of those individuals impacted<sup>2</sup> (Iyioha, 2008; Mosoff, 1998).

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<sup>2</sup> Parin Dossa's 2009 book, *Racialized Bodies, Disabling Worlds: Storied Lives of Immigrant Muslim Women* focuses on the experience of immigrants with disabilities, but without specific attention to the excessive demands provision or the impact of this legislation.

However, there has been a significant amount of research on barriers faced by migrants without permanent status, though this research has primarily been done outside of a Canadian context (Goldring et al, 2009) and not specifically pertaining to those who also experience pre-existing disabilities. Nonetheless, for immigrants with disabilities living with temporary or no legal status in Canada, there are multiple layers of disadvantage. The most easily identifiable disadvantage is a lack of access to those resources and social services that are explicitly only made available to permanent residents or those with forms of documentation dependent on status. In a Canadian context, much of the analysis on such barriers to access has centered on access to the healthcare system (Bernhard et al, 2009; Goldring et al, 2007) and access to documented work (Albrecht et al, 2009; Brubaker, 1989). Access to employment is noted by immigrants as not only being financially necessary, but also necessary for facilitating settlement and increasing feelings of agency and worth (Albrecht et al, 2009). Access to settlement services, many of which are funded only to serve documented clients, may also be an issue (Bernhard et al, 2009, Goldring et al, 2007). Other services may not be explicitly denied to undocumented migrants but may be effectively inaccessible for other reasons, such as the demand that an individual present valid identification before being given access to housing (Harris, 2003). As well, migrants may not be aware of which services are available to them without permanent status, or may avoid accessing services for fear of discovery and deportation (Goldring et al, 2007). Such concerns may block access to key services such as shelters and educational services (Bernhard et al, 2009) while also leaving migrants without recourse when victimized by domestic violence or other crimes. Lack of access may also be experienced by the Canadian-born children and other family members of people without permanent status, as they police their own access to services or have their access policed by others for fear of drawing attention to the family member's status (Bernard et al, 2009). In addition, living without status may have long-term implications for the mental and physical health of immigrants and their families and lead to feelings of depression and hopelessness resulting from an overwhelming lack of agency based both in disability and migration status (Albrecht et al, 2009; Simich, 2009). When extended family and social networks have been lost through the process of migration, immigrants might also experience significant isolation. Such isolation can leave immigrants, particularly immigrant women, vulnerable to abuse in their intimate relationships. This vulnerability is increased if the individual is dependent on her spouse for status or economic

survival (Dossa, 2009). In the context of these stressors and barriers to access, pre-existing disabilities and medical conditions may be exacerbated and new ones may appear (Albrecht et al, 2009). Barriers to access in migration for people with disabilities, and the lack of services and supports for immigrants without status suggest a complex relationship between migration status and disability. The physical, social and systemic barriers encountered by immigrants with disabilities are accompanied by, and based in, the oppression experienced by immigrants and people with disabilities. Oppression directed at immigrants and oppression directed at people with disabilities is not only dually experienced by immigrants with disabilities. Rather, the two forms of oppression are informed by one another in the experiences of immigrants with disabilities, and may be further influenced by other intersecting oppressions.

### *Intersecting Oppressions: Immigration and Disability*

Stienstra (2003) asserts that “the lives of people with disabilities are shaped by their racial and ethnic status, their religion and their first language” (1). Disability, immigration status, race, ethnicity, religion, language and other factors, impact the way in which people are understood in the world. As argued by Albrecht and his colleagues (2009), both immigration and disability “have considerable symbolic and political meaning” (p. 259). The barriers in access experienced by irregular migrants within Canada, regardless of disability status, may be similar to those experienced by people with disabilities in Canada, regardless of migration status. Like irregular migrants, people with disabilities experience barriers in the labour market, social services and housing. They are subject to negative stereotypes and are disproportionately impacted by domestic violence and other forms of crime (Mosoff, 1998). This occurs despite the existence of human rights legislation designed to protect the rights of people with disabilities (ibid).

For Canadian residents who don't apply for permanent status, or who are denied it based on the excessive demands provision, the barriers experienced as a result of temporary or irregular status in Canada are compounded by the challenges that may already be presented by factors such as ableism, racism, classism and xenophobia. Additionally, general challenges of migration such as social isolation or struggles to reestablish networks and communities in a new environment might be made more difficult for immigrants simultaneously negotiating disability,

identity and the systemic ableism of a new environment. Social networks in the immigrant's country of origin might also have played an important role in providing support and accommodation, facilitating access on a daily basis. Losing these networks to migration can impact accessibility and mobility in the receiving country (Stevens, 2010). As well, for some migrants, oppression based in areas such as race, ethnicity, religion, language or class may be new experiences.

Migration places individuals into a new social context, where identities that previously placed them in a dominant position are now marginalizing. An example of this shift in status would be an individual who was of the dominant or privileged group in their own country and who becomes racialized upon entering Canada. Another example would be of an individual whose class status drops through the process of migration (Albrecht, 2009; Dossa, 2005). Expanding an intersectional analysis to include the linked impact of disability and immigration status allows researchers to critically examine the ways in which immigration policies and practices create barriers to migration and settlement for people with disabilities and to address the complexity and combined effect of the ableism, racism and anti-immigrant sentiments that immigrants with disabilities may experience at both systemic and individual levels.

### *Resistance and Agency Among Immigrants With Disabilities*

While it is important to acknowledge the structural barriers experienced by immigrants with disabilities, it is also important to recognize the agency and resistance with which many immigrants respond. Resistance is included as a primary theme within this research in order to circumvent traditional depictions of marginalized individuals as passive victims of circumstance and inequity. Resistance challenges both the medical and social models of disability by refusing a construction of people with disabilities as victims either of their own minds and bodies or the buildings and policies that surround them. Instead, people with disabilities are embodied agents, refusing victimization and utilizing a plethora of strategies of resistance (Clare, 1999; Shildrick & Price, 1998). This is not a new theme in the disability rights movement or within the academic field of critical disability studies. Resistance has been practiced through the reclamation of language (Clare, 1999), through challenges to dominant research tools and patterns (Shakespeare, 1996) and through resistive storytelling (Dossa, 2005; Dossa, 2009;

Grenier & Hanley, 2007). Dossa (2005) highlights the role of resistance through her case study of Mehrun, a Muslim woman with polio who came from Uganda as a refugee. As a new immigrant to Canada and as a racialized woman with a disability, Mehrun experiences isolation and the devaluation of her skills. By involving herself in organizations and committees, Mehrun is able to align herself with other community advocates to build a sense of agency and develop strategies of resistance in response to her personal experiences of discrimination. In her 2009 book, *Racialized Bodies, Disabling Worlds*, Dossa further explores the stories shared by Mehrun and four other racialized Muslim women with disabilities who have immigrated to Canada and reflects on the multiple ways in which these women engage with and resist the systems they experience in Canada. In addition to self-advocacy within organizations or encounters with service providers, resistance is practiced through their assertion of their individual and cultural identities in the spaces they inhabit. Dossa (2005) argues that such strategies allow individuals to create “meaningful space where they can assert their identity as persons first rather than as disabled individuals” (p. 2534). She further notes, however, that “what they can and cannot do—the realm of possibilities—are determined by historical and social circumstances” (p. 2534). Ultimately, Dossa concludes that the strategies of resistance available are still shaped by pre-existing policies and conceptualizations of disability. As Dossa’s research indicates, resistance can be identified as a theme within the intersecting narratives of migration, and disability and in addressing the challenges posed by negotiating disability, migration and access within Canada, individuals build strategies of resistance and strength.

Another important element to be mindful of in researching the lives and experiences of immigrants with disabilities is that, despite the struggles that can be linked to living as an immigrant with a disability in Canada, the immigrants with disabilities interviewed by Sandys (1998) uniformly identified their lives as better in Canada. This finding does not negate the existence of multiple locations of discrimination. Instead, it suggests that, despite systemic barriers to immigration and settlement, individuals are developing strategies to resist their exclusion and reestablish their identities in a Canadian context. Dossa (2009) explains, “rarely do the excluded Others speak from a discrete space. They critique the larger system from an embodied understanding of its workings, and they engage with it to remake their worlds” (24).

Immigrants with disabilities navigate barriers and utilize them as points of social activism, community organizing and individual empowerment.

Amanda Grenier and Jill Hanley's research on older women and resistance to conceptions of frailty is relevant in developing an understanding of the resistive strategies of immigrants with disabilities, as notions of frailty are closely linked with those of dependence and incompetence placed on immigrants with disabilities. In the same way that resistance and organizing allows older women to subvert "prescribed gendered and age-based assumptions about older women and their bodies" (Grenier & Hanley, 2007; p. 211), immigrants with disabilities are able to challenge dominant assumptions of ability, ethnicity and immigration. Grenier and Hanley (2007) also emphasize that resistance can take place both in private and public domains. While resistance may take the form of highly visible campaigns and traditionally vocal activism, other actions may also constitute resistance. Public validations of these acts as resistive may be limited or rendered invisible by dominant notions of protest, but at the same time these acts serve to build the agency of the resistor (Grenier & Hanley, 2007). The very process of personal survival undertaken by immigrants with disabilities, in which community agencies and individual networks are accessed to meet physical and social needs, reframes the responsibility for care as communal and outside of an institutional framework.

Storytelling, a research tool used by Grenier and Hanley as well as Dossa, is framed as another resistive strategy. In presenting personal experiences, individuals engage in "embodied resistance" by placing their own experiences in opposition to dominant assumptions of their held identities (Dossa, 2005; Dossa, 2009). In his spoken word piece, "The Magic Wand", Lynn Manning articulates: "Quick-change artist extraordinaire/I whip out my folded cane/and change from black man to blind man/with a flick of my wrist ... My final form is never of my choosing/I only wield the wand/You are the magicians" (Manning, 1994). In current literature, researchers frequently enact this transformation. Speaking of the worlds that participants are involved in "unmapping and remaking" (Dossa, 2009; 130) through storytelling, Dossa reminds the researcher/listener: "We are part of this world, both in the way in which we are implicated and as agents of change working *with* and not *for* our research participants" (ibid. original emphasis). Through storytelling, marginalized individuals give voice to their experiences and offer definitions and meaning on their own terms. By preserving the words and stories shared by

participants, the researcher has the opportunity to challenge traditional research dynamics and reduce the exploitative potential of research with marginalized populations. Stories shared by immigrants with disabilities provide a forum in which identity can be explored using the intersectional analysis that is frequently absent in the literature on both immigration and disability.

The relegation of the experiences of immigrants with disabilities and their families to single sentences in the body of literature on immigration prevents individuals and organizations—including policymakers—from analyzing the impact of ableist policies and practices in immigration. In addition to increasing academic knowledge, an expanded body of research on the experiences of immigrants with disabilities, addressing both processes of migration and daily realities of oppression, would serve as a guide to activists and frontline workers in determining the future directions of programming and advocacy.

### **Statement of Purpose and Research Focus**

This research utilizes a critical disability perspective, identifying barriers to access as a product of an ableist immigration system, not as a result of individuals' disabilities. The primary aim of this research project is to better understand the impact of the excessive demands provision on the lived realities of immigrants with disabilities, including routes of migration, negotiation of disability in medical exams and immigration applications, and the post migration settlement experience. The excessive demands provision included in the 2001 Immigration and Refugee Protection Act is reflective of an immigration system in which access is dictated by the perceived value or cost of the potential migrant to Canada. Ableist constructions of individuals with disabilities as inherently unproductive and wholly dependent fundamentally exclude them from participating in this system as independent immigrants, with the excessive demands provision invoked when denying access.

Current writing on the excessive demands provision critiques the legislation from a theoretical perspective, identifying the ways in which immigration policy continues to focus on the market-value of the immigrant and the cost, or burden, of disability. While authors such as Iyioha (2008), Mosoff (1998), and Stienstra (2003) have provided an adept analysis of the

legislation itself, the voices of immigrants with disabilities have been largely absent in this work. A limited amount of research exists on the impact of immigration policy on lived experiences, on barriers to migration for people with disabilities, on the impact of irregular status on access to services and migrants' wellbeing, and on strategies of resistance to dominant notions of migration and disability. Thus, the intersection between these areas remains largely unexamined and is a gap that has been identified by other authors. Steinstra (2003) states, "Much more research is needed to develop our understanding of the different perspectives and inequalities ... that immigrants with disabilities face". Sandys (1998) further notes, "studies on immigration and settlement most often ignore the issue of disability".

Research considering immigrants and people with disabilities as distinct groups creates a context in which immigrants with disabilities will be represented as members of either one group or the other, never both. As a result, the unique identities, experiences and needs of immigrants with disabilities have not been adequately addressed within immigration studies. It has been argued that examining such particular intersections within research creates too small of a sample and limits the applicability of the research (Hum et. al, 2003). This particular challenge was one experienced by Finch and his colleagues in researching acculturation stress among immigrant communities in the United States—the researchers found that immigrants who identified as people with disabilities rated their mental health post-migration as significantly worse than did immigrants without disabilities (Finch et. al, pg. 251). This finding was only briefly mentioned, however, because of the small number of respondents in this category: only 8 of the 1000 total respondents self-identified as having a disability. Similarly only 13 immigrants with disabilities were accessed as participants in research by Sandys (1998). The low number of research participants does not necessarily reflect the actual numbers of immigrants with disabilities—a Manitoba program connecting immigrants with disabilities to social services, for example, serves between 150 and 200 clients annually (Kirbyson, 2008). Immigrants and people with disabilities have been most frequently represented as two distinct groups who are isolated from, or in competition with, each other. While it is true that immigrants with disabilities compose only a small percentage of the overall population, they are a population that has been explicitly referenced in immigration policy through section 38(B) of IRPA, and also a group with documented experiences of difficulty in immigration and settlement.

My research is an initial response to this identified gap in research, and recognition of the links between disability, irregular migration, settlement and resistance. To this end, I have recruited three individuals who have self-identified as persons with disabilities and who have immigrated to Canada to share their experiences of immigration and disability in loosely structured interviews. By asking immigrants with disabilities to share their stories of migration, my goal in this research is to trace how the excessive demands provision impacts the lived realities of people with disabilities before, during and post-migration.

This research is based on a social model of disability. The focus on policy as disabling, the questions posed to research participants and the lens through which participants' narratives have been analyzed all work to reject the conceptualization of immigrants with disabilities as fundamentally impaired. The historic and contemporary exclusion of immigrants with disabilities, including the excessive demands provision, reflects the Canadian government's reliance on the medical model in understanding disability. Policy such as the Immigration and Refugee Protection Act presents disability as a threat, and exclusion as a natural consequence of physical or mental deficiency. By interpreting the same policies and excluded peoples through a social model of disability I hope to suggest the ways in which the excessive demands provision can be understood as exclusionary and disabling policy, developed and maintained in the context of larger institutions that uphold and reproduce systemic ableism. Simultaneously, I recognize the challenges to the social model of disability. Particularly, I do not want to portray the participants in my research as unresponsive to the ableism present in their lives and immigration stories. The participants in my research do not simply have policy and practice imposed on to them; rather they actively experience the systemic inequity in their lives and respond to it. Dossa (2009) summarizes, "The body does not remain silent" (139). I hope that my use of narrative research has emphasized this responsiveness.

My work is also informed by feminist disability studies. Critical theories of identity, including critical race theory and feminist theory do not replace or duplicate each other, but can inform each other (Asch, 2001). Like the social model of disability, feminist disability studies have challenged the understanding of disability as an inherent physical or mental deficiency and have refocused attention onto the systems and structures that construct barriers. Additionally, feminist disability studies have included recognition that the concept of disability and the

categorization of particular bodies as disabled are, in themselves, social constructions. Bodies and minds are not only disabled by restrictive policies and practices, but by an artificial distinction between categories of able and disabled. Feminist disability studies not only offer a conceptual framework by which to understand disability and embodiment, but one that reflects the experiences of gendered bodies. While I did not initially consider a gendered analysis central to this research project, this shifted throughout the course of my research. In questioning why only female-identified people had expressed interest in participating in this project, I began to consider more closely how gender might inform experiences of disability and migration. I have used a feminist disability studies perspective to address some of these considerations.

My focus on the immigration experiences of people who have negotiated their own migration stories, and are negotiating them on an ongoing basis, is also based in an anti-ableist approach. A central goal of this research project is to recognize people with disabilities as active participants in their own immigration experiences and to identify and celebrate strategies of resistance utilized by immigrants with disabilities. In so doing, I work to recognize the diverse ways in which resistance can be manifest, both in private and public domains.

### *Methodology*

This is a qualitative and interpretive study. My goal was to interview three to five individuals who self-identified as people with disabilities who had immigrated to Canada. Five potential participants made contact between November 2010 and March 2011, three of whom chose to participate after learning more about the project. The limited scope of recruitment for this research is reflected by the small pool of participants. The three participants shared their experiences of immigration and disability in loosely structured interviews. These participants were: Amelia, a 34 year old woman from the United States living in Canada on temporary permits, Paola, a 36 year old woman from Mexico who had obtained permanent residency in Canada through family class immigration, and Nasrin, a 54 year old woman from Pakistan who had also obtained permanent residency through family class immigration. All participants identified as female and as university educated. Beyond these similarities participants' identities varied widely, as did the stories and experiences they chose to share. Narratives will be analysed both against the research questions used, and for any previously unidentified themes or

links between immigration and disability status. The final research findings will be structured based on the themes and patterns identified by research participants.

Research participants were initially recruited through recruitment materials sent to two community health centres in downtown Toronto in November, 2010: one primarily serving immigrants and refugees, the other serving a large population of people with disabilities. The centre serving immigrants and refugees was receptive to the call for participants and placed information about the project in their offices and waiting areas. The other centre did not respond to the request and, during a follow-up visit, there was no indication that the information had been shared. The call for participants did move beyond its initial posting. Those who expressed interest in my research shared that they had been forwarded the information by friends and colleagues. I had initially hoped to continue recruitment through snowball sampling, but this proved very difficult as every participant commented that they had never met another immigrant who identified, at least publicly, as having a disability.

My difficulty in recruiting participants might also reflect a broader disinterest or distrust in research. As many critical disability theorists have noted, there has existed a longstanding fixation on the disabled body. From the circus freak show to academia and medicine, people with disabilities have often been fixated on and gawked at and treated with horror, pity and contempt in an attempt to dissect the abnormal (Llewellyn & Hogan, 2000; Clare, 1999). While I attempted to make clear in my recruitment materials that my research goal was to examine or dissect the impact of policy and not the research participants themselves, hesitations around my research, or weariness around research in general, might have discouraged other potential participants. Additionally, living in an ablest society, while simultaneously trying to navigate an ableist immigration system, might discourage individuals from disclosing disability. As Sharon Dale Stone (1995) explains, “In a world in which people with disabilities are objectified as the alien ‘other’, it makes sense to work at passing for normal; to pretend that one has nothing in common with ‘the disabled’; it makes sense to ignore the ways in which we can identify with living in a body that has impairments” (421). The stigma around disability might prevent disclosure of disability both generally and in the context of my research project.

#### *Accommodation and Adjustment*

Participants were initially provided with the option of meeting either at a downtown university campus or in their own homes. These options were expanded to include virtual meetings through the online tool, Skype, which provides free voice and video communication through an internet connection. This option was included based on feedback from potential participants who indicated that restricting interviews to in person meetings limited accessibility for individuals whose disability impacts mobility and for individuals living outside of the downtown core. Two participants chose to be interviewed in their homes, while the third chose to be interviewed via Skype. The format of the consent form was also modified from its original printed form: my own ingrained ableism is identifiable in my initial failure to consider that a traditional printed format might be inaccessible to individuals with learning disabilities or visual disabilities, for example. The consent form was made available to participants prior to our meeting through an e-mailed digital copy and, in one instance, was also repeated verbally at the beginning of the interview.

Interviews were loosely structured using guiding questions, but focussed on asking participants to share their own experiences of disability in the context of immigration. In “Rules of Engagement: doing disability research”, Tom Shakespeare (1996) explains his use of similar formats over more structured interviews or questionnaires. He indicates that the “aim to equalise the research relationship, and give participants some control over the process, over their words and over their participation” (116). My decision to impose minimal structure on the conversations I had with participants was based in similar goals and a desire to provide participants with the opportunity to share their own stories and experiences. The prompts that were provided included asking for information on barriers experienced both in the immigration process and in Canada, as well as asking for immigrants’ responses to any barriers experienced. The decision to ask very few demographic questions was also intentional and participants were not asked to disclose the nature of their disability, though all referenced this information at least in part. This was intended to decentralize disability as a limitation and refocus on the systems of migration as limiting structures.

Disability advocates and researchers (Shakespeare, 1996; Petersen, 2011) have discussed the importance of what they refer to as “gain” in research or, in other words, the potential benefit of the research process or findings to research participants. They emphasize that research with

people with disabilities should not be conducted only for the benefit of the researcher, but because it can directly or indirectly benefit individuals or communities of people with disabilities. I was not offering any financial compensation for participation in my research and I cannot guarantee that policy will shift as a result of this writing. As a result, it was important for me to consider the ways in which participants could benefit from the research process itself. The qualitative research undertaken by Dossa (2005, 2009) emphasizes the value of storytelling as a tool of resistance. The first person retelling of personal experience and identity allows the speaker to determine the content shared and the method of sharing, and this places the storyteller as agent of their own experiences. These stories may then be shaped to emphasize a particular message or experience, eliciting understanding or action from the audience and serving as a tool of resistance. Through narrative research, participants are recognized as “producers of context specific knowledge” (Dossa 2009: 4). The use of storytelling as a method of data collection has the potential to not only to gather data on resistance, but also to frame the very research process as a tool of resistance. In addition to looking for stories of resistance in participants’ existing migration narratives, I hoped that, by choosing to participate in this research, participants could use a public telling of their stories as a further resistive act. In their research with older women, Grenier & Hanley (2007) found that the focus on narrative in their research “served to offset the powerful constructs imposed on older women’s bodies, as well as to allow them space to present their more legitimate ‘sense of self’ (212). Neuman (2006) further notes that the point of view expressed through narrative is “that of a motivated actor who expresses intentions” (475). I hope that the use of narrative in this research project has allowed participants to position themselves as motivated, intentional actors in the research project and has supported, not detracted from their agency.

### *Researcher Engagement*

In my position as researcher, I did not originally intend for this project to include a self-reflexive component. As a graduate-level student, I am well aware that research is subjective and that this subjectivity operates on the topics, questions and theories highlighted. I recognized what is articulated so well by Tom Shakespeare (1996): “independent research is indeed

ultimately a fiction” (117). Regardless, I expected to maintain a certain degree of detachment from the work. Through the course of my initial research, participant recruitment and interviews, it soon became apparent that this approach would be challenged both by participant questions and my own engagement with the narratives that participants shared. On the initial point, I was challenged both by research participants and potential research participants to locate my own interest in the topic before they shared their own stories. One woman, not a research participant herself, wrote in an e-mail:

*“this may sound like an unusual question, but it tends to be really important in our community ... I'm wondering if you might identify with the disAbility community or what brings you [to] this project.*

*I feel discomfort forwarding calls for research participation to my network of peers when we feel "studied" ...*

*I hope I haven't offended you, but I think this is important work and I think it's important to understand and be sensitive to the role of relationship and exploitation.”*

Similar questions were issued by participants prior to interviews, or in the context of interviews. While my own relationship to ability/disability is tenuous, and my identification as a person with a disability vacillates between location and context, as a Canadian-born, visibly able-bodied woman, I am often afforded the privilege of not being asked to identify myself. This privilege comes from belonging, in many ways, to that imagined category of “normal”: which is a “category obscured by its own privilege” (Garland-Thomson, 2005, 1557). I had not, initially, taken into account the power dynamics that this privilege could reinforce in a research setting. Conversations that took place with participants, and other interested parties, about own engagement with the subject challenged me to locate myself as an active participant in my own research and to reconceptualise my own relationship to research participants moving beyond the position of a detached observer. After completing my research interviews, I came across an article written by a self-identified middle-class, white woman reflecting how, in her earlier research, she had negotiated her relationships with the women of colour with disabilities who participated. She wrote: “It seems as though by not sharing more about myself, I fail to develop a relationship with the participants; subsequently, I fail to create an environment where they feel inclined to share about their lives” (Petersen, 2011). This article had not been published as I met

with participants. I was fortunate in that participants asked me to locate myself and contextualize my interest. From interview to interview, and throughout the course of each interview, I found myself more and more engaged in: “sharing my intentions, articulating my interest in their lives, sharing my own stories, and answering their questions” (Petersen, 302). As one interview seemed to be drawing to a close, the participant asked: “*It’s fascinating. Why did you... I mean, did you know somebody with a disability that was in this situation or...?*” as I answered, our conversation continued and gained added dimension. I hope that my own engagement in this interview and others increased comfort and deepened conversations. Simultaneously, I wonder how much richer a dialogue could have been created if I had been more forthcoming about my own relationship to the research question and how many more conversations might have been initiated with individuals who, perhaps, chose not to reply to a call for participants from an unknown researcher.

In regards to my own engagement with participants’ narratives, I was particularly struck by the stories of participants whose immigration had been facilitated by an able-bodied partner. As noted above, my own identification as able-bodied is not complete or uncomplicated, but I am read as able-bodied in almost all contexts and afforded the accompanying privilege within the educational, health and social systems in which I operate. My identification in regards to citizenship is far less nuanced: I am a white, third-generation Canadian who speaks English as my first, and only, language and as such I experience all of the privilege of my race, language and citizenship. While my partner shares my race and language, my partner is also a person with a disability whose permanent status in Canada was achieved through Family Class immigration and through my role as a spousal sponsor. As research participants reflected on the role of their able-bodied partners in facilitating their migration, I entered in to a deeper examination of my role as a sponsor and the power dynamics that might be imbedded both in sponsorship and ability/disability in my relationship.

## **Findings**

In our conversations, I asked participants about their experiences with the excessive demands provision. In response, participants spoke about how their disabilities had been, or might be assessed and imagined how much of a demand their disabilities might be understood

from the context of the doctor performing an immigration-related medical exam or the immigration officer assessing their applications. Success in these assessments was associated both with how visible participants' disabilities would be to the medical practitioner, and participants' ability to convey independence and productivity in both the medical exam and overall immigration applications. In imagining how their bodies and lives might be understood, participants also shared how they viewed themselves in relation to the excessive demands provision. These conversations are reflected in the "Assessment of Ability" and "Visibility of Disability" sections below.

At the beginning of our conversations, I asked participants to share their migration histories and current immigration status with me. I have used "Application Status" to introduce the findings section because of the impact that immigration status can have on settlement in Canada— an impact that is evident both in existing literature and participants' own experiences of migration. Though permanent status in Canada facilitates access to many of the health and social services guarded by the excessive demands provision, participants made it abundantly clear that there were specific barriers to settlement in Canada for immigrants with disabilities, even with permanent status. Participants' experiences of immigration and settlement as people with disabilities are described using the themes they identified: "Access to Services", "Isolation" and "Experiences of Disability Here and There". Participants also made it clear that their immigration narratives were impacted by intersections of identity beyond disability and migration status. These intersecting identities, particularly gender and educational background, are described under "Intersections of Identity". Finally, stories of advocacy and resilience were shared by all participants and are a primary focus of this research. These stories are included as the final theme below titled "Resistance".

### *Application Status*

I began all conversations with participants by asking them to share their current status in Canada and their stories of migration. Participants' legal status in Canada and experiences of migration were influenced by how their disabilities were read in the context of the excessive demands provision and subsequently influenced their access to services and experiences of settlement in Canada.

Of the three participants in my research, Amelia had not yet applied for status or undergone the accompanying medical exam; Nasrin had undergone the medical exam in the context of her now completed application for permanent residency and Paola had undergone the same medical examination twice: once when applying for a student permit and once when applying for permanent status. Amelia has lived in Canada for over eight years as a temporary resident. When I asked her why she had not applied for permanent residence she initially explained, *“The first couple years it was mostly because I didn’t know how long I was going to stay in Toronto and Canada, and after that it’s been a variety of factors”*. Later, when discussing the excessive demands provision, I asked her if she would have applied for permanent status if this legislation was not an issue or if she had not been aware of it. She replied, *“Yeah, that’s what’s kept me from applying. Because I don’t want to go through all that work and spend all that money—because actually it costs money to apply—and then be turned down”*.

Paola had initially also come to Canada as a temporary resident, on a student permit. Her decision to come first as a temporary resident was not based on the excessive demands provision, but rather her uncertainty as to whether or not she would be able to settle successfully in Canada. She explained, *“I needed to make sure that Canada in general and Toronto in particular was a place where I would be able to stay”*. After living in Canada for three years as a temporary resident, she was included as a common-law spouse on her partner’s immigration application and is now a permanent resident. We spoke of her experiences both as a temporary and permanent resident in Canada. Her experience as living both as a temporary resident and permanent resident in Canada allowed her to comment on the barriers that were resolved by obtaining permanent status, and those that remained ingrained in the systems and structures she accesses, or is still denied access from, as a permanent resident.

Nasrin entered Canada having already obtained permanent residence through her husband’s family class application. After immigrating to Canada in 1997, she returned to Pakistan for a year after struggling to settle and find both social supports and employment. She re-immigrated to Canada in 1998 for the purpose of family reunification but, more than a decade later, still struggles with settlement in Canada.

#### *Assessment of Ability*

People with disabilities applying for permanent residency in Canada not only have to contend with the ableism imbedded in the excessive demands provision, but also with the assumptions or values that might be held by medical practitioner performing the medical exam and the immigration officer assessing the application. Though participants' specific knowledge of the excessive demands provision varied, all were aware that their immigration applications would be assessed with attention to how their disabilities were presented and understood. This assessment was raised as a significant theme in all interviews as participants imagined how they might be judged by a doctor or immigration officer. In discussing these evaluations of disability and demand, participants also engaged in a process of self-reflection, examining their own bodies and imagining how they might be received.

Both Amelia and Paola were aware of barriers to permanent residency for immigrants with disabilities when they came to Canada as temporary residents. Paola became aware of these barriers when first researching her immigration options. When I asked her about whether or not she had been aware of any policies or practices that might impact her immigration when she first came to Canada as a student she explained, *"I was, in general terms. I had done some research, um, so—yes, I was, although not specifically as when I was, indeed, applying"*. Amelia had become aware of barriers for immigrants with disabilities through a news article forwarded to her by a friend. The news article Amelia spoke of described a woman with multiple sclerosis who had been denied permanent residency based on disability. Amelia remembers her response as, *"well great—well I guess I won't be able to stay in Canada ... But, um, I didn't quite realize what an impact that would have"*.

Paola also referenced media coverage of a specific case, which she had been aware of when considering her own immigration process. As occurs through the excessive demands provision, a blind student had been refused permanent status in Australia. Paola had read this story while waiting for her own immigration application to be processed. She explained the impact of this media case on her own confidence, saying, *"He was exactly my case, you know? He was a student in Australia and then when he graduated he applied to be a permanent resident and he was refused status ... you know, when I read that I was like, 'Oops. What will happen with me?'"*. Though the case Paola described took place in the context of the Australian immigration system, she found the similarities between this case and her own unsettling.

Amelia's initial concerns about barriers in immigrating to Canada as a person with a disability had also developed from her knowledge of another country's immigration system. She explained, "*I mean I knew that the immigration system in the US was flawed in numerous, numerous horrible oppressive violent ways. Um, so I assumed probably that the Canadian immigration system would also be flawed in similar ways. It turns out it is*". Amelia and Paola's awareness both of systemic ableism in immigration systems generally and the of the excessive demands provision specifically meant that they were aware that they would be assessed not only on their individual qualifications when applying for status in Canada, but specifically as people with disabilities.

Amelia explained her experiences of the healthcare system, both within and beyond the context of an immigration-related medical exam by saying:

*"only some bodies work the right way and the normal way—which is like the able-bodied people—and then all of the other people who either think differently, or move differently, or have bodies that exist outside of that really narrow norm are wrong, or broken, or pathologized, psychiatrized, like they're just made into the other."*

In discussing their experiences of the excessive demands provision, all participants contemplated how their bodies and minds might approximate the "narrow norm" that Amelia spoke of, and in what contexts they became an undesirable other. When participants imagined how their bodies might be assessed, they spoke of assessment from several sources. I asked all participants about how they had been, or could be, understood in the context of an immigration-related medical exam. In response, participants spoke about how their health and ability might be understood by a medical practitioner and how the visibility and cost of their disabilities might be read in a medical context. Amelia had not undergone an immigration-related medical exam, but was preparing to apply for permanent residency and knew that a medical exam was inevitable. Speaking generally, she said, "*whether the appearance comes in the form of your physical presence in the doctor's office; or whether the appearance comes in the form of medical histories ... I think that both of those things could negatively impact your experience in that examination*". I asked Amelia whether she felt she would be visible in terms of both, and she agreed. Paola had gone through two medical exams when gaining temporary and permanent status. She remembered being concerned as to how her disability was being read in the medical

environment. When speaking to the doctor performing her medical exam, Paola emphasized her independence and the fact that she would not be seeking treatment for her disability. When telling me about this conversation, she wondered about how the doctor had shared this information in his report: *“I honestly am not sure if he wrote that. I’m sure that he wrote that I’m blind, in the report, whatever. But I’m not sure, but I wish I had known how he had phrased it”*. In these medical exams, the doctor both receives information about immigrants’ disabilities and also produces it in the form of a report. As both the receiver and transmitter of information about applicants’ disabilities, a doctor performing a medical exam for the purpose of immigration shapes how disability, health and demand are conveyed to Citizenship and Immigration Canada. They are both the first assessors of immigrants’ medical admissibility, and the only assessor that applicants will directly encounter. As such, it is no surprise that these medical exams feature prominently in both Amelia and Paola’s experiences of the excessive demands provision.

Nasrin was the only participant who had not experienced disability as an issue in an immigration-related medical exam. She explained that disability had only been raised as an issue when she was applying for citizenship, by the person assessing her application: *“I think there was a lack of information on the part of the people there who were kind of evaluating my medical or my information. That was the issue, I think. So it needed more information from my physician and my ophthalmologist.”* In Nasrin’s account, the assessment of the medical practitioner and the assessment of the immigration officer are interlinked in determining whether she is eligible to immigrate to Canada.

Paola and Amelia also commented on how their application for residency might be read by an immigration officer. They spoke both in terms of disability and the medical exam, and also work experience, skill and ability. Amelia commented, *“I know that the immigration system is completely ableist and would probably consider me a drain on social resources”*. In contrast, Paola hoped that her education and language abilities would overshadow any concerns that Citizenship and Immigration Canada might have regarding her disability. Paola explained, *“[The doctor] was asking me, ‘Ah, do you have any problems with your eyesight?’ and, so, it became very apparent that it would be kind of an issue, but honestly I did not want to think about it. I thought that I was very qualified”*. Later Paola described how she had explained her

disability to the doctor who had performed her medical examination for the purpose of permanent residency:

*“[The doctor] asked something for how long I had been blind, and I said ... basically, “for all my life, but I want to make it clear that one, I am functional and completely independent; and two, my blindness is permanent, there is nothing to do with it, in other words, I won’t be seeking any medical treatment; and three, again, I’m independent. I do not need a caregiver.”*

Similarly to Paola, Nasrin identified the minimal cost she would pose to the Canadian state as a reason that her immigration application should receive approval explaining: *“because the medical system itself cannot do anything about [her disability], right? So, it’s kind of like, even if I fall they have that policy ... my disability has no economic consequences”*. In interactions such as these, participants indicated how they might be understood as desirable or undesirable in the context of a cost-benefit model. Desirability is presented both through the ways in which participants’ bodies and minds can approximate the constructed ideals and also in the other skills, qualities and attributes that might compensate for or overshadow disability.

The individual biases of a medical practitioner might not be wholly evident within the context of the exam, and the individual assessing the immigration application is entirely unknown to the applicant. As a result, the applicant can only speculate as to what assumptions and understandings of disability might be held by the people assessing her suitability for permanent residence. As previously identified, Paola had wondered about how her disability had been understood by the doctor who performed her medical exam. She explained, *“I did not have any access to that information, and he did not tell me, and—you know—I have no way of knowing.”* As applicants cannot know the biases or ableist assumptions of the medical practitioner impacting their application or the Citizenship and Immigration Canada employee assessing it, they must engage in self-assessment against a standard of health and normalcy that they are unable to pinpoint.

Foucault’s conception of the Panopticon is relevant in this case: unable to witness their observer, controlled populations will police their own behaviour, “caught up in a power situation of which they are themselves the bearers” (Foucault, 1977; pg. 53). This element of self-assessment was evident in participants’ comments on their own health and ability. When

describing her own initial reaction to the excessive demands provision, Paola explained “*I always thought that being blind- it would not, probably, be such a drag on the— you know— public resources*”. Later, in her reflection on the medical exam, Paola expressed hope that disability will be less of an issue because of her qualifications. She explained that she was comfortable in her self-assessment based on the number of points she had scored on a sample skilled worker application and also because of her age, language abilities and education. While Paola indicated very legitimate concerns with how her disability might be read in a medical context, grounded in her uncertainty as to how she had been received by the doctor in the medical exam, she was also able to minimize her anxieties regarding the assessment by positively assessing her own skills and strengths.

### *Visibility of Disability*

One way in which participants understood how their disability would be assessed was in terms of visibility. As identified by Amelia, disability can be rendered visible either in terms of how bodies are physically read as normal or abnormal or through individuals’ medical histories. Speaking of her own disability, Amelia noted, “*My disability is very apparent*”. Paola also commented on the visibility of her disability, when speaking of how she had been received in her initial medical examination as a temporary resident. She explained, “*I went to a qualified doctor. And he was asking me—I have a guide dog—and he was asking me...*”. From here, Paola went on to describe how the doctor had raised disability in the medical exam. The qualifier that she has a guide dog was offered as an explanation as to why the doctor had raised questions about disability. This came up again when I asked Paola if disability had been raised as an issue again when she applied for permanent status. She responded, “*Of course. I mean, I’m obviously blind, in the sense—you look at me, and my eyes don’t look any different, but I have a guide dog and he went with me.*” Implicit was the assumption that if Paola had not had a guide dog, and had her disability not been otherwise visible in the medical context, these questions would not have been raised. The assumption that invisible disabilities might escape examination in a medical context were reinforced both by my partner’s experience of disability in the medical examination—my partner raised the issue of disability and was told that it was not an issue—and by Nasrin’s experience of the medical examination.

Nasrin explained that disability had not been raised as an issue at all in her application for permanent residence to Canada. When I asked her why she thought this was, in the context of the excessive demands provision, she explained immediately: *“Because my disability is more invisible, right?”* The direct correlation that participants drew between the visibility of their disabilities and their experiences of medical assessment for the purpose of immigration suggests that the excessive demands provision operates from an imprecise science. The demand that an immigrant—with or without an identified disability—might place on health and social services is not determined through an in depth examination of the immigrant’s health, ability or experience. Rather, an evaluation of an immigrant’s health and ability seems to occur in direct relation to what is visible or understood as disability in the context of the assessors’ individual biases.

### *Access to Services*

Entry to Canada through irregular, temporary or permanent status did not guarantee participants access to the health or social services guarded by the excessive demands provision. Rather, participants identified several barriers to accessing services and supports in Canada. For Amelia and Paola, who had both come to Canada with only temporary status, access had frequently been impacted by services only available to permanent residents and citizens. Amelia, who is reliant on attendant care services, commented on her ineligibility to receive publicly-funded care as a temporary resident saying, *“Canada says no because I’m not a citizen or resident and then the US says no because I’m not living there. So then I have no access to funds”*.

As university students at the graduate level, both Paola and Amelia spoke of access in reference to services accessed in the school environment. Amelia described difficulty in accessing services both from the centre for students with disabilities and the centre for international students at her university. In attempting to access services she encountered a lack of experience regarding the intersection of disability and temporary status from staff in both environments. Paola shared specific difficulties she had experienced in accessing her course readings, saying *“I did have some access issues to my readings at the university, ironically enough “*, but also commented more broadly on lack of access, as a temporary resident, to funds and bursaries available to students with disabilities.

The other area of access that both Amelia and Paola commented on was healthcare. While Paola felt that the access to healthcare provided by the university-provided health insurance (UHIP) was sufficient, Amelia had experienced difficulty finding doctors who would recognize this plan. She explained: *“It’s finding doctors and stuff that will actually take UHIP as opposed to OHIP. And when you go into the doctor’s office and you’re like, ‘Here’s my insurance’ they’re like, ‘What is this? We don’t know how to, like, work with this at all’, right? So, um, that’s been a bit of an issue”*. While access to healthcare services was complicated by UHIP versus OHIP coverage, both Paola and Amelia had the benefit of some access through their universities’ insurance. For temporary residents not covered by any insurance plan, lack of access to healthcare could be much more central an issue.

Nasrin’s status as a permanent resident provided her with access to services that might not have been available to Amelia or Paola as temporary residents. Despite this, she found settling in Canada such a challenging experience that she returned to Pakistan a year after migration. She explained:

*“I immigrated in 1997, then what happened was, of course, the difficulties of immigration: not being able to find employment, not being able to sustain family and myself we moved back—like, I moved back. My husband stayed. I moved back with my children, just to support myself and the kids”*.

Nasrin’s struggle to settle even with theoretically open access to services is indicative of a reality shared by all participants. Barriers were posed not only by the formal access requirements of agencies and services but by service providers’ lack of awareness regarding their particular needs. Amelia had attempted to access services for people with disabilities, but had found that these services were not set up to address the specific needs of newcomers to Canada or people without permanent status. Nasrin also commented that services for people with disabilities *“mostly focus on white, or on those people who are already settled in Canada. They are not aware of issues relating to immigrant women, specifically”*. Participants identified a parallel lack of support from agencies serving immigrants and newcomers to Canada. Speaking of the services she had received from a settlement agency within her community, Nasrin explained *“they were very sensitive to immigrants, to immigrant issues, but I think the focus on disability was just not there”*. While immigration status or newcomer experience might be recognized

within immigration or settlement agencies, Nasrin found that accommodation or understanding of disability was lacking. Amelia summarized her experience of this parallel lack of support by saying, *“I went to, you know, services for students with disabilities... I went to, like, the service for you know, international students and everybody was just like, [mimicking] ‘We have no idea what to do for you!’”*

Like Amelia, Nasrin went looking for existing services and supports for immigrants with disabilities. Immigrating outside of an academic context, she was uncertain as to where she should look. She spoke in detail about her difficulty finding services that would recognize her needs and experiences: *“I had no knowledge whatsoever, and it took me about two to three years to get to the kind of help- or whatever kind of help was available, I came to know about it after two to three years ... And then there were gaps in my services: my access to service.”* While my original focus had been on the excessive demands provision, these conversations suggest that challenges regarding the intersection of disability and immigration status are just as prevalent following migration. While access to permanent status in Canada resolves some issues, a lack of understanding and targeted services still impacts settlement post-migration. As Paola commented wryly, *“So, you know, there are issues everywhere. You think one problem is solved, but there will be more problems”*.

A major concern identified by all participants was difficulty in finding employment and, connected to this, economic status. When I asked Amelia if she had experienced difficulties accessing health or social services as a result of not having permanent status, she explained: *“Any time my wheelchair breaks down while I’m in Canada I have to pay for it out of pocket and I’m a graduate student so I don’t have a lot of income. Like, I live below the poverty line and wheelchair repairs are really expensive”*. Here, the impact of not having access to publicly funded healthcare is deepened by lack of financial access. For Amelia, living below the poverty line impacts access to services along with immigration status and disability. While Amelia links her current status as a graduate student to her socioeconomic status in the above quote, both she and the other participants identified employment and financial access as long term concerns of settling in Canada.

As a current fulltime student, Paola was not looking for employment when we spoke. Regardless, speaking about her future in Canada, Paola shared *“I’m beginning to dread the time when I begin looking for a job”*. While Paola commented that this was a concern shared by all immigrants, Nasrin explained her struggle to find employment in more specific terms:

*“I couldn’t do those, you know, start up jobs or survival jobs. Like, go into customer service or work in the farms because of my visual impairment ... And, of course, my mobility was a huge issue. I couldn’t do- I don’t have a driver’s licence, so not being able to navigate in the city or the environment- that was an issue”*.

The fact that certain jobs were inaccessible to Nasrin as a result of disability and restricted mobility was fundamentally linked to her difficulty settling in Canada. Though she had permanent status her experiences of disability and immigration to Canada were still intrinsically connected to the systemic ableism she experienced within Canada. The issues beyond the excessive demands provision that participants described when speaking of their settlement in Canada indicates that while immigration legislation might serve as an initial barrier for immigrants with disabilities, it is only one obstacle among many. After arriving in Canada participants continue to experience individual and systemic biases with discrimination levelled at them based in disability, immigration status and the intersection of the two.

#### *Experiences of Disability “Here and There”*

At one point in our conversation, Paola began to share how she had experienced her disability differently in Canada and in her home country of Mexico. Speaking of the difficulties she had in negotiating disability in her home country of Mexico. She paused and explained, *“I mean, it’s hard for me to say it, but really I do not have all the things I need to be as independent as I am in Canada in Mexico.”* Paola seemed to find it difficult to criticize her home country, but also the comparison between Canada and her home country was more complex than a simple story of improvement through migration. Speaking of her experience in Toronto, she explained, *“I have found people to be more... what’s the word I’m trying to look for? Colder I should say. You know, people don’t talk about the disability because it’s not politically correct.”* Though Paola’s mobility had increased through migration, she had found conversation about disability more open in Mexico. Continuing to explain her experience of disability in Canada, she said:

*“I think that in Canada there’s respect, maybe more understanding, but also at some points I have felt that the equity that persons with disabilities might be able to achieve might be sometimes mistakenly, mm, how can I say this? Equity, I find that sometimes, almost as indifference ... In that sense I think that equity can be mistakenly understood as indifference. Or, not understood, but that’s the end result”.*

Amelia and Nasrin had also experienced disability differently between Canada and their home countries. For both of them, the different experiences of accommodation and support they found in these locations resulted in an ongoing transnational relationship, as they tried to establish themselves in Canada while maintaining the support they had received in their countries of origin. For Amelia, this support was primarily financial. Speaking of the money she received in the United States for wheelchair repairs and disability support income, she said, *“I’m reliant on that income right now. So, for a while I waited to apply for citizenship because I wanted to get a new wheelchair before I applied, because the funding is better in the US than it is in Canada for getting new wheelchairs”.* She described trying to delay the need for wheelchair repairs until she could return to her home country, explaining that the price of a plane ticket was often less than the cost of repairs at a Canadian institution.

For Nasrin, the support she received in her home country was emotional as well as practical. Nasrin did speak about the practical barriers to settlement in Canada at the beginning of her interview, but later reflected on another element of support that she had experienced in Pakistan but found lacking after migration to Canada. She spoke wistfully of her experiences of disability in Pakistan, saying,

*“my disability never even existed for me. Because it was so much taken care of, it was like there was always support available, and the support was so consistent and it was so pervasive that I didn’t even feel the disability. Well, of course I felt the disability personally, internally, but in terms of my functionality it didn’t occur to me that I had a disability, right? Simply because of the family support and the interventions that were required to support me, they were available to me”.*

As a permanent resident in Canada, Nasrin has access to publicly funded health and social services but still found the systemic support she previously experienced lacking. The difficulties she experienced in settling in Canada resulted in her returning to Pakistan with her children a year after initial migration. Though she eventually returned to Canada for the sake of family

reunification, it was not based on a desire to access accommodations and supports from publicly funded services. Nasrin's final message regarding her immigration to Canada was clear: *"certainly my future would have been far more, you could say, far better than it is, provided I had not immigrated"*.

### *Isolation*

Isolation was not a theme that I had anticipated. In fact, when beginning my research, I had hoped to identify other potential research participants through snowball sampling. Instead, participants explained that they did not know other people with disabilities who had succeeded in immigrating to Canada. This was highlighted in Paola's inquiry about my research process, namely her interest in how I had found research participants. She asked, *"but where do you find them? Where do you look for them? Online?"* Paola's interest in where other immigrants with disabilities could be found reflects the isolation from others in similar circumstances experienced by all participants. In every interview participants commented that they did not know other immigrants with disabilities. Beyond not knowing other immigrants with disabilities, Nasrin stated simply *"I don't think people with immigrant status identify as disabled people"*.

Amelia described being surprised by the lack of other dually identified immigrants with disabilities when she first came to Canada: *"When I first came to Toronto I looked into ... what existed. I was like, 'Surely I'm not the first international student with a physical disability who requires attendant care.'"* She went on to describe service providers who were not aware of how to support her, and who had apparently not encountered others in this situation. Later in our conversation, Amelia spoke about being contacted, years later, by the same centre for students with disabilities that she had tried to access when first immigrating:

*"I got contacted by the [centre for students with disabilities at her academic institution] being like, 'Oh, hey...' Being like, 'Oh, there's this person that is interested in doing a Masters here at York, but he needs 24 hour care... So, how did you figure out that whole, being in a PhD program needing attendant care thing?'"*

Amelia was not aware of whether this student had successfully immigrated to Canada, and had not met other individuals in similar circumstances. She struggled to think of other immigrants with disabilities that she had encountered in her eight years in Canada, but finally concluded,

*“I’ve heard stories of other people, but I don’t know many other people who are like, actively pursuing it.”* Here Amelia was referring to individual cases where people had considered immigration but had not pursued it because of the barriers posed. The lack of awareness and support that Amelia experienced both when first immigrating and when being contacted regarding this student suggests that people with disabilities immigrating to Canada do so in isolation from others, and without a context of established advocacy and networks of support. It appears that this apparent invisibility may be connected to the fact that immigrants with disabilities might fear disclosing their status, based on potential stigma. Nasrin explained,

*“There are a lot of stigmas attached to disabilities. And I think, because, simply because, immigrants are already stigmatized, they’re already discriminated against, they feel that if they are going to identify themselves as – disabled- it would be kind of like they will experience double discrimination. So I think, out of fear of double discrimination- intersection of disability and immigration, immigration status, I think people want to stay away from there.”*

While Amelia and Paola had both learned of other people with disabilities impacted by immigration legislation through media sources, these media accounts did not provide a sense of community or support. Rather, accounts of people denied permanent status because of disability served to discourage them or raise concern about their own admissibility to Canada.

### *Intersections of Identity*

My call for research participants specified only that I was looking to speak with people who were over the age of 18, had immigrated to Canada from another country and had a disability. I did not specify the gender, race, class, educational background, sexual orientation, country of origin, type of disability, or current status in Canada that participants should possess. At the beginning of our interviews I asked participants for their age, gender and country of origin; beyond these categories, self-identification varied between participants and I did not ask for further identification. Despite this, all participants identified the ways in which their experiences of immigration and disability had been informed not only by each other but also by other identities and experiences, whether these identities enabled or disabled access.

In speaking to how her experiences of medical systems and immigration processes had informed each other, Amelia identified the regulation of bodies as a primary aim of both

systems. She emphasized that the regulations imposed by these systems were not specific only to immigrants or people with disabilities: “*definitely, ableism, classism, racism, sexism. All of those -isms play out.*” In referencing how intersections of identity “play out”, Amelia recognizes that access and mobility are controlled not only by systemic ableism, but by intersecting oppressions. Other participants commented similarly on how their access within Canada had been impacted by more than just disability and immigration status, but also by their other intersecting identities. The multifaceted ways in which these intersecting oppressions “play out” was evidenced by participants’ explanations and understandings of their own experiences. In addition to age and gender, participants identified markers such as race, class, language, sexual orientation and education as intersecting identities that might either provide advantages or pose barriers to immigration, but almost certainly complicated it.

In some cases, intersections of identity provided participants with a point of access. This was particularly evident with regards to education. All participants were highly educated, possessing graduate or doctoral degrees. Their fields of knowledge and expertise varied-- critical disability studies, political science and philosophy—but they shared privilege granted by post-secondary education and certification that is recognized and valued. Participants reflected on the advantage that their academic background provided them. As Paola explained, speaking about her joint immigration application with her partner, “*I always thought that if I had ended up having a problem, I would be able to appeal the decision based on our credentials and our—you know, both of us are skilled professionals*”. Later in the interview, speaking about accessing services in Canada prior to receiving permanent residency she explained: “*my status as a permanent student really helped, you know, in the sense that I could get some things through the university*”. In these two statements, Paola reflects both on how both academic experience and certification, and academic institutions themselves can support immigration and settlement. Amelia also commented on the access she has as a university student and employee, and the benefit of her education was also evident in her telling of her immigration story, which included significant academic analysis and terminology.

Though all participants shared the benefit of educational experience, engagement with academic institutions was tempered by the gaps in administrators’ understanding of disability and inadequate accommodation. Paola spoke of having to advocate before course readings were

provided in a format accessible to her, *“I did have some access issues to my readings at the university, ironically enough. I mean it was... the system was not very well designed”*. Commenting on the centre for students with disabilities on her university campus, Amelia spoke more emphatically about the lack of support available: *“I was so not supported by them at all. So the fact that they were like, you know... five years later were like, ‘Oh, I wonder how she managed to, you know, get around this completely exclusive system.”* Conversations such as these reflect a complex negotiation between the access provided by post-secondary education and the barriers created by institutional ableism embedded within the academic environment. While membership within an academic institution has offered many benefits to participants, including status in Canada for both Amelia and Paola, access has been incomplete and complicated by lack of understanding, resources and support around both immigration status and disability.

Nasrin spoke extensively about her experiences as an immigrant woman, and how her experiences might differ from those of a man immigrating with a disability. Explaining the struggles she had experienced when immigrating to Canada, she said,

*“first of all you are navigating and you are an immigrant, then if you are a woman it becomes harder because you come from a society that ... is more protective towards women. Here when you are left alone you don’t have those protections- those social protections- which society expects- which you expect from the society to give you”*.

Neither Amelia nor Paola commented on their experiences of immigration or disability specifically in regards to gender, and no participants commented on the ways in which intersections between other identity markers such as race, sexual orientation or language might have impacted their immigration experiences. Despite the limited discussion of intersections of identity, Nasrin’s reflection on her experiences not just as an immigrant with a disability but as an immigrant *woman* with a disability reveal that the narratives of immigrants with disabilities are impacted by much more than the intersection of disability and immigration status.

### *Resistance*

The use of the term resistance in this paper is my own, with no participant identifying their experiences of immigration or settlement as including acts of resistance. In fact, when I

asked Nasrin if she had taken any steps to make sure her needs were met, she responded clearly: *“No. [laughs] No advocacy whatsoever. Never. Because, first of all you just feel you won’t get any opportunity for anything, right? So, whatever opportunity you’re going to get, you’re not going to ruin it by telling people you need accommodations”*. Despite Nasrin’s negative response, both she and other participants described many acts that I interpret as resistive. Later in our conversation, when Nasrin was explaining how she had established a life in Canada without readily available social supports, she explained: *“because the interventions were not present for me I had to bring the interventions into my own life”*. She did not treat this as an act of resistance or advocacy, but as a necessary task in the given context. As an outside observer, I understand the situation differently—witnessing Nasrin and other participants as individuals who have refused to accept circumstances as presented and who are actively negotiating their own stories of migration and disability.

Participants have advocated both within academic and social institutions and outside of them to ensure that their needs are met. In the absence of access to funded attendant care services, Amelia has created what she describes as a “care collective”, a group of friends and community members who volunteer their time to support her in her daily needs. She explained her care collective by saying, *“I just have a crew of about 40 active people that sort of come and help me live and survive and stay in Canada, because that’s the only way I could establish it”*. This explanation suggests that, for Amelia, self-advocacy is not only an option, but the only method of survival in a context that does not recognize or support her needs. As previously indicated, Paola and Nasrin both treated self-advocacy as a given act in contexts where their needs would not otherwise be met. Explaining her response to inadequate accommodations in a university setting, Paola explained *“but, of course, me being me, I began lobbying and talking to people and trying to change the system and eventually things did work out”*. I asked Paola what lobbying looked like for her, she told me that she *“talked to people, argued, you know, explained things, tried to talk to other people if the first person didn’t respond”*. Comments such as these provide an example of how participants did not pose resistance as either a possibility or impossibility, but rather as a necessary response to the inaccessible systems they experience.

Participants’ orientation towards resistance was also evident in their willingness to challenge the excessive demands provision through their applications as people with disabilities.

When I asked Amelia where she saw her life in Canada going from this point, she explained: *“I’m thinking that the time is coming that I’m going to have to apply either way, right? And if I don’t get residency, or if I get denied, I’ll have to fight that as well”*. It was interesting to me that, for Amelia, it was simply a given fact that she would challenge a negative decision. While Paola’s permanent residency had already been approved, she was similarly adamant that she would have challenged a negative decision. In speaking about her qualifications as a skilled worker Paola explained, *“I always thought that if I had ended up having a problem, I would be able to appeal the decision based on our credentials”*. For both Amelia and Paola, self-advocacy had been such an ingrained aspect of their lives—in academic institutions, settlement in Canada and beyond—that they simply assumed that they would continue this in the context of immigration to Canada.

## **Discussion**

The women who chose to participate in my research came from different countries and experiences. They spoke different first languages and had migrated under different circumstances. Though their experiences with the excessive demands provision had also been very different, participants shared the experience of having to negotiate migration and settlement in the context of policies and practices that pose barriers to people with disabilities. All of the participants in this research project could potentially have been denied access through the excessive demands provision. Yet all three are living in Canada, and both Paola and Nasrin have been deemed admissible for permanent residency. In our conversations, participants described many factors influencing how their disabilities were read and understood by medical officials and immigration officers. Participants cited the visibility of their disabilities in a medical context and the ability to emphasize productivity over demand as primary factors facilitating or impeding their applications for permanent residency. They shared methods by which they had attempted to control how their disabilities were presented and interpreted, but also situations in which the interpretation of disability was beyond their control. In each case, the ways in which disability and identity were presented and interpreted in the context of the excessive demands provision directly impacted participants’ experiences of immigration to Canada. Participants emphasized that the impact of disability on their migration narratives did not end with the excessive demands provision. Post-migration, immigrants’ lives are impacted by how they are

received and understood at the intersection of migration status, disability and other identity markers.

Regardless of which immigration stream a potential immigrant applies through, significant paperwork and documentation is required. The spousal sponsorship application submitted by my partner and I, for instance, required us to document education, employment, and residence, as well as our relationship itself, through photos, letters and numerous forms. The mandated paperwork of immigration applications serves as a very particular role in controlling movement and access. Dossa (2009) explains: “Paperwork has become an integral part of our reality. It is a medium used by the state to monitor and police people, internally and on the borders. The heavy hand of this process is felt strongly by people on the margins of society” (102). Among those on the margins of society are immigrants with disabilities.

None of Canada’s immigration application forms ask applicants to disclose disability. Rather, it is assumed that the mandated medical exam will function as a screening tool to determine whether an applicant is inadmissible for permanent residency based on the demand their health condition(s) could potentially pose to Canada’s health or social services. As a result, the doctor performing the immigration-related medical exam is tasked with interpreting demand. Disability is still broadly understood through the medical model, both individually and systemically. This model interprets disability as an illness or burden, incompatible with health or productivity. Ultimately, if an individual is read as disabled in a medical context they risk being automatically interpreted as an excessive demand, despite the 2001 Supreme Court challenge that resulted in instructions to visa officers to consider the individual immigrant’s situation and resources before applying the excessive demands provision. Sharon Dale Stone (1995) notes that all people experience impairment at some point or in some context but that, “only a minority of the population has disabilities that cannot be concealed” (417). Participants spoke clearly about how the ability to conceal disability might impact the results of the immigration related medical exam, and all cited the visibility of disability as a factor influencing their experiences of the excessive demands provision.

Disability had not been raised as a significant issue in Nasrin’s medical exam, which she attributed to the fact that her disability was, as she said, “*more invisible*”. Paola commented on

the relative visibility of her disability by qualifying her comment, *“you look at me and my eyes don’t look any different”* by explaining, *“but I have a guide dog and he went with me”*. Her explanation of how she had been received as a person with a disability in her medical exam was grounded in this dual explanation of visibility. Alternately, Amelia has been discouraged from applying for permanent status based on the physical visibility of her disability and the ways in which it is encoded into her medical history. These encounters reminded me of my partner’s immigration related medical exam, which I was present for as support. My partner’s disabilities are not immediately physically evident and, seeing an apparently able-bodied person, the medical practitioner was not looking for them. He looked at my partner, and then at the form he was required to complete. He began filling in the form, speaking aloud as he did: *“heart good, lungs good ...”* he continued narrating his positive assessment until my partner interrupted, feeling obligated to disclose disability. The doctor looked again at this apparently able body and interrupted, *“You’re fine”*. While this encounter, and the relative invisibility of disability, facilitated my partner’s migration to Canada, I began to wonder how different the encounter had been if my partner had come in with a guide dog, or a cane, or in a wheelchair. In witnessing how much of my partner’s health and ability was assumed based on physical presentation in this encounter, I began to think about how an alternate physical presentation might be understood as illness or demand. This encounter is what initiated my current research.

In addition to how disability was physically represented, whether or not this representation was consciously manipulated, participants’ experiences of the excessive demands provision were shaped by how their bodies and experiences were interpreted through a cost/benefit model. The interaction Paola recounted from her medical exam, in which she explained to her doctor, *“I am functional and completely independent; and two, my blindness is permanent, there is nothing to do with it, in other words, I won’t be seeking any medical treatment; and three, again, I’m independent. I do not need a caregiver.”* illuminates the relationship between an immigration system utilizing a cost/benefit system to determine an immigrant’s worth and a medical model of disability that equates disability with illness, dependence and lack of productivity. Immigration policy and practice, including the excessive demands provision, determines an applicant’s admissibility to Canada based on what they will offer the country in terms of economics or skill while simultaneously attempting to avoid a drain

on health or social services. The medical model of disability, upheld by the excessive demands provision, imagines disability as being incongruent with productivity or health, and “people who have disabilities are reduced to being social services consumers who cannot give but only receive” (Dossa, 2009; 79). This reduction provides the grounding for the excessive demands provision. In the context of established immigration policies and practices, immigrants with disabilities must work against the equation of disability with demand in order to gain status in Canada.

The information Paola gave to the doctor performing her medical exam, “*my blindness is permanent, there is nothing to do with it: in other words, I won’t be seeking any medical treatment*” was echoed by Nasrin’s explanation for why her disability had not been a significant issue in gaining permanent status, “*the medical system itself cannot do anything about it, right? ... My disability has no economic consequences*”. Paola and Nasrin’s shared assertion that their disabilities do not require medical intervention challenges the medical model of disability and the understanding of disability as demand. They acknowledge their disabilities but offer medical practitioners and immigration officers an alternate interpretation that challenges the dominant ableist view. While challenging the assumed link between disability and dependence, emphasizing independence from care also suggests the need for support as a negative. Nasrin and Paola challenged assumptions of disability and demand in their assertions of independence, but simultaneously distinguished themselves as preferable to those applicants who might require “excessive” support. In the context of the excessive demands provision and a cost/benefit analysis, people with disabilities attempting to gain status depend on this distinction. However, the requirement issued through the excessive demands provision—that immigrants not place demand on Canada’s health and social services—is one that “no body” can fulfill. Regardless of disability, applicants for Canadian residency are required to perpetuate an unsustainable myth in order to gain approval in the context of the excessive demands provision.

Dale Stone (1995) refers to this as the myth of bodily perfection. Though all people experience impairments and barriers of one sort or another, the myth of bodily perfection invokes fear and shame around bodily difference. As a result, impairment is denied and relegated only to people with disabilities. A related myth is that of an isolated body: one that does not ask for support, place demands or require care. The isolated body, demanded by the

medical exam and enacted by those trying to avoid its scrutiny, is unsustainable in at least two regards. Firstly, as I have alluded to, all people place demand and access supports. The supports that are needed, wanted or available may shift between people and contexts. The conceptualization of who is responsible for support, be it friends, family, community members, public services or private institutions is also unstable, influenced profoundly by individual and cultural belief. Regardless, we all place demands and meet the demands of others. We utilize resources, and also are resources. The excessive demands provision ignores both the demands that people without disabilities place, and also the resources that people with disabilities offer. Secondly, ability is not stable. For good reason, many disability activists and scholars have referred to people without disabilities as “temporarily able-bodied”, sometimes shortened to “TABS” (Gerschick, 2000). Whether through ageing, illness or injury, our bodies and minds shift. People who are not currently recognized as having a disability may well have one later. As Garland-Thomson (2005) explains, “if we live long enough, we will all become disabled” (1568). The attempts to avoid disability that are imbedded in immigration policy and practice are not sustainable, either immediately or on an ongoing basis. While the excessive demands provision certainly succeeds in barring individual access to some, it avoids neither disability nor demand.

As identified by the social model of disability, disability is not a distinct physical or mental category, nor is disability a neutral term with a single meaning. As Titchkosky (2007) notes, “Whenever disability is perceived, spoken or even thought about, people mean it in some way” (12). The understanding of disability as an undesirable demand that is embedded in policy and practice might contradict participants’ own understandings of their bodies and experiences. While Paola noted her independence in her medical exam, she also worried that her qualifications might not have been noted by the doctor performing the exam. As she explained, “*I honestly am not sure if he wrote that. I’m sure that he wrote that I’m blind, in the report, whatever. But I’m not sure, but I wish I had known how he had phrased it*”. Though Paola was confident that she would not pose an excessive demand, she was uncertain as to whether this assessment would be shared by the medical practitioner viewing and assessing her disability. At other points in our conversation Paola spoke about her qualifications as an immigrant, mentioning factors such as education and language abilities, but she also worried that these

qualifications would not be enough to counter ableist assumptions about disability. Such concerns suggest that disability might not only be visible in the context of an immigration application, it might be the only thing visible.

Though both Nasrin and Paola expressed concern about how their disabilities would be read and interpreted by medical practitioners and immigration officials, they were able to present ability and independence in a manner that contradicted the assumptions about disability that are imbedded in the excessive demands provision and informed by the medical model of disability. As noted, Nasrin and Paola's ability to offer an alternate reading of disability was aided by the minimal visibility of their disabilities in a medical context and should not be understood as contradictory to the ongoing impact of the excessive demands provision. In exploring the myth of bodily perfection and the experiences of women with visible disabilities Sharon Dale Stone (1995) explains, "we know from listening to the experiences of women with visible disabilities that observers often have difficulty noticing anything other than the disability" (416). As such, emphasizing both independence and ability might aid some immigrants with disabilities in gaining status but might not be either feasible or sufficient for others. The ways in which Amelia's disability is visible and rendered pathological has discouraged her from applying for permanent residence. Her negotiation of the excessive demands provision has taken a different form. Though she has not applied for permanent status, she has lived in Canada for over eight years as a temporary resident and facilitated access to care through the collective she has organized.

It is interesting to note that both Paola and Nasrin's immigration occurred through family sponsorship and was supported by an able-bodied partner. This aspect of their narratives struck me particularly as I am the family class sponsor of my partner's immigration. In order to be approved as a sponsor, the family member of the potential immigrant must commit to providing the sponsored person with financial support for two years. This sponsorship is designed to circumvent the immigrant's potential utilization of the social services hypothetically protected by the excessive demands provision. Through the requirements of sponsorship, the familial relationship is exploited as an alternative to publicly funded care. The utilization of these family relationships as a system of support is not inherently negative. As noted by Amelia and Nasrin, care and access can be facilitated through the informal channels of family and community

support in a way that is positive and affirming. Speaking of the importance of her care collective, Amelia explained that it allows her to *“live and survive and stay in Canada, because that’s the only way I could establish it”*. Nasrin’s description of the care and support provided by family and community members in her country of origin, that was lost through the process of migration, lent similar importance to networks of support other than institutional services. As she explained, “back home you have a social structure: you have a whole support structure built around your disability”. Grenier and Hanley (2007) describe how the provision of care through these social and familial networks can resist dominant notions of health and social services as solely institutional, relocating them within a system of communal support. However, as identified by Dossa (2009), family class sponsorship is predicated on the assumption of dependency and “erases the contributions of sponsored immigrants” (4). She further notes that a large number of those sponsored are women or elder immigrants, unto whom dependence is already frequently projected, with racialized women specifically “construed as recipients, rather than givers, of care” (Dossa, 2009, 24). As discussed, immigrants with disabilities also experience the ableist assumption that they are both unproductive and burdensome, reinforced by the roles defined through sponsored migration. The imbalance in power implicit in the roles of sponsor and sponsored may be heightened by the individuals’ relative disability status. While Paola and Nasrin described their relationships in neutral or positive terms, immigration that is reliant on a partner’s support may increase the sponsored partner’s vulnerability to abuse, particularly in the context of other racialized, gendered and classed power dynamics (Dossa, 2009).

As well as accessing support through informal or family-based channels of care, participants have established many routes of access to health and social services within Canada. Access has been facilitated by permanent residence, engagement with non-profit agencies, membership in post-secondary institutions and individual advocacy. Despite these routes of access both to migration and settlement, participants also described many barriers. Paola and Amelia, who had originally come to Canada as temporary residents, experienced barriers to services and supports only available to Canadian citizens and permanent residents. In addition to the health and social services described by the excessive demands provision, both described academic grants and funds not available to them as temporary residents. Barriers to access were

more complicated than those simply based in legal status, however. As Dossa (2009) emphasizes, citizenship is not synonymous with full access: “only members of the dominant group enjoy substantive rights. While others may hold legal citizenship, this does not translate into economic, health care, and civil rights” (69). Even Nasrin, who had obtained permanent status prior to her migration, found many established services inaccessible. This inaccessibility was largely based in service providers’ failure to recognize and accommodate for those who are both immigrants and people with disabilities. Participants found that even services specifically mandated to meet the needs of immigrants or people with disabilities were unprepared to accommodate the aspects of participants’ identities not set out in this mandate. The experiences that participants shared of settlement services ill-equipped to meet their needs as people with disabilities is one that is echoed in existing research on the experiences of immigrants with disabilities in other countries. Both in the United States and England, settlement services have been identified as being unaware of the particular needs of immigrants with disabilities and unprepared to meet their needs (El-Lahib & Wehbi, 2011). While social services must necessarily identify target populations, doing so without adequate knowledge or experience to address the intersections of identity creates challenges for individuals who experience multiple points of marginalization. None of the participants in this research project described existing programs or services that addressed their needs as immigrants, as people with disabilities, and as immigrants with disabilities. Instead, participants attempted to meet their needs by engaging with programs and services both for immigrants and disabilities, and by acting as educators and advocates for their own needs within these spaces.

Despite multiple barriers to immigration and settlement, all participants were living in Canada and had established points of access. Participants had taken multiple routes to establishing this access. In addition to navigating the excessive demands provision, participants had worked to develop the systems of support they required, both by advocating within existing systems and by developing a broader understanding of support than the one offered by the excessive demands provision. As Dossa (2009) explains, “Faced with a system that does not accommodate or address their needs and aspirations, people on the margins of society seek out multiple ways to survive within, in between, and outside the system” (18). Nasrin spoke of the important role that family and community had played in facilitating access in her home country,

and Amelia had worked to establish a similar system of support through the volunteer care collective she has created in Canada. These routes of access are indicative of an understanding of support and care that goes beyond access to government-funded health or social services. As described, participants shared stories of advocating within existing services, independently creating alternate systems of support and successfully negotiating migration to Canada in the face of ableist conceptions of health and demand. These stories place immigrants with disabilities as active participants in their own migration stories, not as victims of discriminatory policies or practices. By choosing to share their stories, participants also utilized storytelling as a resistive strategy. As Tanya Titchkosky explains, “Words on disability are themselves a doing, are themselves a way of knowing; such words reside among us and help to make our fate as embodied beings” (7). I would argue that the same is true of any aspect of identity. How we talk about ourselves, and how we are talked about, influences how our identities are understood and performed. As a result, storytelling exists as “one venue through which a person can express herself in her own terms and reconstruct her life/her-story in the act of telling” (Dossa, 2009; 92-93). By articulating their own experiences of disability and migration, participants offered a challenge to a dominant conceptualization of disability and framed the narrative about disability and migration included in this research. As the researcher, I had established a focus on the excessive demands provision. Participants shared this focus, but also directed their narratives and identified other topics of importance. Consequently, many of the themes discussed in this paper are included directly as a result of participants’ own shaping of the research.

Ultimately, the intersection of disability and migration status does not fully account for participants’ experiences of immigration and settlement in Canada. As Dossa (2009) identifies, “race and gender matter and that these social markers of difference cannot be dismissed under the seemingly neutral category of disability” (5). As women, participants’ experiences were also impacted by the ways in which mobility and access are gendered. Amelia noted generally that, in immigration, “*ableism, classism, racism, sexism. All of those -isms play out*”. Nasrin was also very clear that her experiences were not of an immigrant with a disability, but as an immigrant woman with a disability. She explained, “[*settlement services*] *mostly focus on white, or on those people who are already settled in Canada. They are not aware of issues relating to immigrant women, specifically*”. The services for people with disabilities Nasrin had accessed

were not only unaware of her needs as an immigrant, but as an immigrant woman whose concerns and expectations around mobility are impacted by culture and gender in addition to disability. By locating herself as not just an immigrant with a disability but as an immigrant woman with a disability, Nasrin draws attention to the ways in which disability and migration not only inform each other, but are also gendered experiences. In our conversation, she described how she navigated disability in a new environment in the context of gendered expectations. Her individual experience reveals the impact of the systemic disadvantaging of women with disabilities described by Dossa (2009): “Institutional structures, legislation (or the lack of it), and social attitudes seem to have conspired against women who have disabilities. This situation affects racialized women who have disabilities most intensely” (19). I did not ask participants to comment on whether— or how— factors such as country of origin, race or language ability had impacted their experiences of migration. Existing research in the field of disability studies has frequently ignored the ways in which factors such as gender, sexual orientation or race impact experiences of disability (Shildrick and Price, 1998). In her discussion of the welfare of children with disabilities, Strong-Boag (2007) identifies that experiences of disability are “always negotiated in the context of cultural assumptions, existing social supports and barriers, and available technologies” (414). This analysis indicates how immigrants’ experiences of disability might shift through migration, and all three participants noted this when discussing the different ways in which they had experienced their disabilities in their countries of origin and Canada. Simultaneously, the assumptions, barriers, supports and available technologies referenced by Strong-Boag are influenced by more than physical location. Factors such as race, gender and class, also determine how individuals will be understood, what assumptions will be made of them, and what barriers and supports will be available. For these reasons, and as I indicated in my literature review, Dossa (2009) suggests that an intersectional or “pluralistic” approach be utilized within feminist theory, arguing that this can “lead to a more enhanced understanding of the workings of power (structure) and the ways that people remake their worlds (agency)” (156). Though fully exploring these intersections of identity is beyond the scope of this project, participants’ own reflections on how their experiences of disability had varied between their countries of origin and Canada suggest that these intersections would be a valuable direction for future research to take.

## *Strengths and Weaknesses*

Little research has been done on the impact of the excessive demands provision on people with disabilities. One of the strengths of this paper is that it adds to a body of work that draws awareness to the ableist assumptions and negative impact of the legislation and further emphasizes the importance of change. Firsthand accounts by immigrants with disabilities on the impact of the excessive demands provision have rarely been included in the academic discussion of the legislation. While individual immigrants and immigrant families have occasionally been profiled in media reports, these reports have focussed either on emphasizing the value of the individuals profiled or garnering sympathy for the specific case. This media coverage has lacked an in-depth analysis of the excessive demands provision itself, only presenting individual decisions as problematic. The stories shared by the immigrants with disabilities who chose to participate in this research combine the focus on individuals' lived realities present in media reports (Keung, 2011; Wallace, 2011) with the attention to legislation present in the critiques of the excessive demands provision offered by academic sources and advocacy organizations (Chadha, 2005; Mosoff, 1998). Additionally, the focus of this research on the first person accounts of immigrants with disabilities promotes the use of storytelling as a resistive tool. Participants were in control of the information they shared, and they chose what aspects of their stories to emphasize and ignore. In using narrative research, I have attempted to remain aware of the power dynamics imbedded in research and to work with participants in a way that is mutually supportive and not exploitative, fulfilling the responsibility set out by Dossa (2009) to "circulate the stories while minimizing the process of appropriation" (93). In writing this paper, I hope that I have preserved both the stories of struggle and resilience shared by participants and accurately represented the messages that they conveyed.

One of the limitations of this research has been that the scope is constrained by the small number of participants. The number of participants was limited both by my resources as a student researcher, and the number of people responding to my outreach efforts. While five people expressed interest in participating in this project, only three eventually chose to participate and identify themselves as immigrants with disabilities in this context. I believe that the rich narratives shared by participants are the most important aspect of this project. Participants shared many different stories and experiences, with all conveying the powerful

impact of ableist policy and practice on immigration and settlement. However, these shared stories are only a small fraction of those that must exist.

A second limitation of this research also relates to sampling. Participating in research requires a degree of privilege. Participants must be able to access recruitment materials, understand the research topic and have the verbal or written communication skills required by the project. As a student researcher with limited resources, I was unable to offer any financial compensation to research participants. As a result, participants were also required to offer their time and energy with little direct gain. This immediately limited participation in my research to those who had the resources to participate without compensation. For many immigrants with disabilities who are struggling to survive and settle in Canada, this may not have been a possibility. Those who did participate in my research described their current situations differently in terms of employment, settlement and financial stability but shared high education levels and current legal status in Canada. These points of privilege, shared by those who did participate, may well have facilitated access not experienced by other immigrants with disabilities. My research does not, and cannot, capture the experiences of those who are too busy simply living or surviving in Canada to participate in a research project.

Participation in this research project was also limited to individuals currently living in Canada. As previously cited, 0.2% of all immigration applications are refused based on the excessive demands provision (Wallace, 2011). It is likely that other potential immigrants simply never apply for permanent status based on the likelihood that they would be refused. This research cannot capture the stories of those who are not living in Canada because their lives and bodies are seen as posing an excessive demand. As I write, my thoughts keep returning to the student that Amelia described: the international student requiring attendant care who the university simply didn't know how to support. I wonder if he came to Canada, or whether the barriers were too significant. I wonder, if he's living here now and how his needs are being met. I wonder whether he will find a permanent home in Canada or whether the demands placed on him will simply be too great.

Likewise, the small number of participants and the scope of this project limit the intersections of identity and oppression that were addressed in participants' narratives. Factors

such as race, language, country of origin and sexual orientation were not addressed in my conversations with participants or in the writing of this paper. Though I do not consider it a weakness, it is important to note that all of the participants in my research also identified as female. Despite the fact that I did not ask participants to reflect on how their experiences of immigration and disability might be informed by gender or sex, Nasrin raised the topic as relevant. Commenting that her status as an immigrant and newcomer to Canada had not been considered or accommodated for within the disability-specific agencies she had first accessed, Nasrin spoke first generally of immigrants and then adjusted her observation:

*“They are not aware of issues relating to immigrant women, specifically. And I think immigrant women... because I think men are more... men, if you immigrate and you are man, then it’s easier for you to go around here and there, because you’re a man, right? You have more resources and want more freedom, but if you are a woman who has immigrated then of course the challenges are much more.”*

In the context of our interview, this comment appeared as more of an aside than a primary point of interest. Following this quote, Nasrin went on to speak about the ways in which the “white mainstream” views immigrants, but did not specify the mainstream as male or female, and did not comment any further on the role of gender in experiences of immigration. This was the only explicit analysis of gender included in this, or other, interviews. Though Amelia had noted generally that experiences of oppression and regulation in medicine and immigration involve sexism, neither she nor Paola discussed how their own migration narratives might have been informed by their experiences as women. Simultaneously, I did not raise the subject of gender either as a general interview topic or as specific follow up to Nasrin’s observation.

The ways in which gender roles interact with immigration and disability may be most evident in the silences of this research project. In addition to the questions I didn’t ask and the experiences that participants didn’t share, an analysis around gender is impacted by the absence of male-identified research participants. As noted, five potential participants responded to the initial call for participants and to the best of my knowledge, all of these contacts identified as female. The exclusive participation of women with disabilities in my research is particularly striking in the context of the established literature on disability, which has focussed largely on the experiences of men and assumed a singular disabled body that is both white and male (Dossa, 2009; Garland-Thomson, 2005). In considering the intersections of identity and the assumptions

of disability in current research, I am left wondering why women were the exclusive participants in my research. Perhaps, as Nasrin suggested, men are granted more access and mobility and are less impacted by restrictive policies and practices such as the IRPA's excessive demands provision. Perhaps the same institutionalized sexism means that medical officers and immigration officials are more likely to see men's contributions and women's needs. Perhaps there is another narrative about migration, disability and masculinity missing from this analysis.

### *Policy Implications*

While Amelia, Nasrin and Paola have all found ways to exist in Canada as immigrants with disabilities, this does not suggest that Canada's current policies or practices are inclusive or sufficient. As El-Lahib and Wehbi (2011) note, "Placing the emphasis on individual assessments and the families' abilities and willingness to support their family members does not address the structural causes or barriers that lead to the marginalization and exclusion of people with disabilities" (7). Immigration policies must be altered significantly to recognize a broader definition of both worth and demand.

In their current manifestations, the excessive demands provision and immigration-related medical exam create barriers to migration for people with disabilities. The structured medical exam does not provide applicants with an opportunity to challenge why independence is valued and the need for a caregiver is threatening. Instead, to obtain status, they must differentiate themselves from people with disabilities who might require such supports. My partner and I had such conversations around the medical exam. We asked ourselves and each other how disability could be concealed and explained, not if it was or was not relevant criteria. I do not criticize why immigrants with disabilities, or my partner and I negotiated presentations and explanations of disability to meet the definitions of health and demand set out by the excessive demands provision and the medical exam. To challenge the legitimacy of these structures in the process of application would be to risk being denied. However, these negotiations demand that applicants perpetuate the "supercrip" narrative, transcending disability as opposed to gaining status with it.

As indicated by all participants' complex stories of negotiating disability and settlement in Canada, whether as temporary or permanent residents, the intersection between disability and migration to Canada does not begin or end with the excessive demands provision. While this policy certainly does impact the immigration narratives of many immigrants with disabilities, barriers remain for those who succeed in migrating to Canada either as temporary or permanent residents. Further research is needed to determine the ongoing impact of discriminatory policies and practices on immigrants with disabilities. As participants' narratives suggest, simply removing the excessive demands provision or reframing it in a context that recognizes individual abilities and does not stigmatize or exclude people with disabilities is not sufficient. When participants succeeded in navigating the ableism of immigration policy itself, they were still confronted with barriers to accessing services in Canada. Nasrin suggested changes that she would like to see in the supports available to newcomers to Canada, explaining,

*“when I came to Canada I came to learn about whatever services are available to me two years after I had already, you know, gone through all of those hardships. It would be easier if those services were available beforehand. You know, at the time when you get your welcome package for example ... So they can include things on disability and services available, or programs available, or whatever supports are available here in the community”.*

Some shifts towards accessible policies and practices are slowly occurring. In Ontario, the Accessibility for Ontarians with Disabilities Act (AODA) mandates that all businesses and social services be accessible by the year 2025. Despite this progress, individual and systemic biases will take more than the next fourteen years to shift and those experiencing oppression from multiple fronts—such as immigrants with disabilities—will benefit the least from these changes. Meaningful and sustainable change can only occur through a fundamental shift in both how disability and worth are understood. Until policies and practices celebrate the contributions of people with disabilities and stop treating the need for support as a threat, the barriers experienced by immigrants with disabilities will remain.

## **Conclusion**

Throughout the course of my research I spoke to three highly skilled immigrants, who hoped to find employment and settle in Canada. None of these immigrants fit the construction of a desirable immigrant created by the excessive demands provision. In sharing their experiences of immigration and disability with me, participants did not describe their abilities or potential contributions to Canada as being constrained by disability, but rather by the policies and practices that served to limit access. The stories that participants shared with me provided valuable insight into the impact of the excessive demands provision on the lived realities of immigrants with disabilities.

When talking about managing wheelchair repairs in Canada without public support or financial access, Amelia explained *“I just use duct tape whenever possible and have credit card debt to pay for my wheelchair repairs.”* Like other participants, Amelia has developed methods for living in a context where her needs are not independently or consistently met. Duct tape and credit card debt are survival strategies that facilitate Amelia’s access in Canada, but are certainly not sustainable or ideal. As posited in the literature review of this paper, reporting that challenges individual immigration decisions based on the sympathy and worth of immigrant(s) in question are insufficient without broader attention to the legislation that initially defines them as unworthy. Similarly, focussing on participants’ relative success in establishing access in Canada provides an incomplete narrative without simultaneous attention to the legal and social interpretations of disability that require access to be fought for and negotiated rather than granted.

The stories that participants shared describe a relationship much more complicated than a technical barrier to legal migration posed by Section 38(1) of the IRPA. Rather, the excessive demands provision is one manifestation of how human worth is systemically understood by the Canadian state. While the desired immigrant is not explicitly described in opposition to the excessive demands provision, he is manifest in the alternatives to the categories of potential deficiency set out in the guidelines for the medical exam. If “functional deficit” is undesirable, the functional body is desired. If “psychiatric conditions causing significant clinical distress” prevent citizenship, a neurotypical presentation is grounds for inclusion. The desired immigrant is identifiable in the silences of the medical exam and in that hoped for result: “Findings that are unremarkable or minor conditions which normally respond well to short term outpatient

treatment”. Though not as overtly articulated in the excessive demands provision, desirability has also been given a gender, race and class. Through their stories, the participants in my research described the how such intersections of identity and oppression had shaped their experiences of immigration and disability. None of the participants’ narratives are simply a telling of what happens when a person has a disability and also holds the desire to immigrate to Canada. Nor did participants end their stories stop at the point of migration, or with a description of the barriers posed by the excessive demands provision. Rather, they described an ongoing struggle to challenge the continuous and emergent barriers that they experience as immigrant women with disabilities. Dossa (2009) writes:

“Racialized women who have disabilities are not part of the Canadian landscape. Their structural and social exclusion are intense. Yet their stories must be heard if we want to write a different kind of Canadian history: a history where women with different abilities and different cultural backgrounds have an active presence.” (26).

My research would have been profoundly different, and much less rich, I had done only policy analysis. I am grateful to the women who shared their stories, and celebrate their narratives as resistive. I hope that this piece of research can join a larger body of work advocating for policy change and increased access. Simultaneously, I recognize the many stories missing from this research. As well those individuals who have not applied for status or been denied status in the context of the excessive demands provision, there are those who hide disability for fear of retribution and those too busy simply surviving to pause and share their stories. I can only hope that the immigrants to whom these missing stories belong will one day be recognized as more than an excessive demand.

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