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Faith as social capital: Diasporic women negotiating religion in secularized healthcare services

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SYNOPSIS

In an era of unprecedented global migration and neoliberal entrenchments, the phenomenon of transnational gendered caregiving is increasingly being recognized as an outcome of today's global economic system. Concurrently, religion is re-entering what has been assumed to be a secularized public sphere. Drawing on research on the negotiation of religious and cultural plurality in healthcare, we examine how faith—sometimes as personalized expressions, other times as codified, structured and collective—shapes caregiving and illness experiences in the context of healthcare services. Demonstrating the salience of intersectional theorizing, we explore how the racialization, gendering, and classing of religion operate for diasporic women seeking and providing healthcare services in the publically-funded Canadian healthcare system that carries the marks of neoliberal ideologies, and is still largely driven by secular ideals. Rather than silencing their faith perspectives in such contexts, many express agency and civic engagement through their religiosity, mobilizing religion as social capital.

Introduction

The phenomenon of transnational gendered caregiving is increasingly recognized as an outcome of today's global economic system, characterized also by its unprecedented global migration and neoliberal entrenchments. As well revealed by recent research, both caregiving and migration are feminized. The gendered nature of the organization and delivery of healthcare services have been widely critiqued, with emotional work and body care (Dyer, McDowell, & Batnitzky, 2008), informal caregiving, and health inequalities (Bambra et al., 2009) falling along lines of gender. The feminization of healthcare work has led to "the assumption that 'women will do things right' due to their 'caring nature' which has led to the neglect of gender policies" that are crucial to diversity and gender equality in healthcare (Kuhlmann & Annandale, 2012, p. 3). Healthcare services, largely staffed by women, are one arena in which transnational flows have escalated in the past decade, a trend that has been named as one of the most important global healthcare trends today (Connell, 2010). Yeates (2009) has noted the increase in women nurses migrating to First World countries, working in public and private settings. Nurses, as opposed to women domestic laborers, are trained, credentialed, most often work in private and public health institutions and have a stronger position under labor laws, such as in the UK (England & Henry, 2013, p. 560).

In addition to care migration, another global migration pattern is that of religious diaspora, sometimes involuntarily through dislocation and persecution, other times voluntarily to seek better life opportunities or for the sake of religious mission. Along with what has been written on transnational economic and political practices, transnational religious life is also gaining an understanding. For example, Tweed (2006) has explored how Cuban migrants in America utilize their religion to make the unfamiliar home. He has shown how religion is a portable resource in their crossing into and dwelling in a new land. Similarly, Knott (2009) has studied Hindus in Leeds and

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how they have become a faith community, Dwyer (2000) has researched the experiences of Pakistani Muslim women in Bradford, and Nesbitt (2000) has examined Sikhs' experiences of their religious tradition in the UK. Our interest in this article is the intersection of these flows—where religious diasporic communities map onto gendered transnational health workers. Notably, incorporating religion in an intentional manner into intersectional analyses has not been widely taken up, as we have articulated elsewhere (Reimer-Kirkham & Sharma, 2012), and even less so in the context of transnational health workers. We aim to contribute to the growing body of literature that examines the lived religion of diasporic communities and in particular women members who employ their faith to navigate healthcare work.

Drawing on a program of research on the negotiation of religious and cultural plurality in healthcare, this article examines how faith—sometimes as personalized expressions, other times as codified, structured and collective—shapes caregiving and illness experiences in the context of health, illness and healthcare services. We begin with several key definitions, followed by a synopsis of two disparate literatures—first in regard to religion and globalization, second in relation to migration and health workers—in an effort to situate the health workers' stories we present later in this article in contemporary social theory. We then draw on research to explicate how diasporic health workers experience religion as both embodied and intimate, and public and social. We explore how the racialization, gendering, and classing of religion operate for diasporic female health workers in the publically-funded Canadian healthcare system that carries the marks of neoliberal ideologies, and is largely driven by secular ideals. Yet, rather than silencing their faith perspectives in such contexts, many women express personal agency and civic engagement through their religiosity and spirituality, in essence, mobilizing religion as social capital.

Background

Globalization, diaspora and religion

We understand 'globalization' as the increasing flow of people, information, goods, services, and other resources across national boundaries (Wuthnow & Offutt, 2008). Not a neutral term, Beyer (2007) observes the contradictions that characterize globalization discourses:

> The evaluation of globalization oscillates uneasily between utopian promise and dystopian menace. Parallel to this ambivalent attitude has been a very consistent tendency to understand globalization in terms of analytic binaries, especially the spatial distinction between the global and the local, or between universal and particular (p. 98).

These tensions—between promise and menace, global and local, universal and particular—are evident in the narratives of diasporic health workers presented in this article.

We also utilize the term 'diaspora', particularly for its historical religious connotations. The classic case of diaspora is that of the Jewish peoples which involved a process of being scattered globally and community living in foreign sites that resulted in historical, religious, spatial and social ties that transcended borders while remaining anchored to a 'homeland' (Cohen, 2008; Vertovec, 2004). Although the term diaspora is widely applied (and arguably understudied) to ethnic groups more so than religious groups, we use the term strategically here to signal our intent for intersectionality and emphasize the roots of the term as applied to dispersed religious groups tied together with a longing for a homeland. We also use the term in a problematized fashion, in keeping with Bramadat and Seljak's (2009) cogent critique that 'diaspora' is often used as a code word to subtly denote non-White, non-Christian people who do not truly belong in Canada, no matter how many generations they have been here.

Equally important to this discussion are some comments about the term 'religion'. Riis (2012) notes that religion must be considered a social institution that unites collectives around a life-view, an individual perspective, and an organization. The term is anchored by an orientation to the sacred, as Pargament, Magyar-Russell, and Murray-Swank (2005) put it: religion has "a distinctly meaningful reference point: the sacred" (p. 665). Religion has traditionally been understood in relation to institutionalized and creedal faith communities, however the term is being stretched nowadays to incorporate a plethora of diverse, individualized ways of seeking the sacred. While many emphasize the distinction between spirituality and religion, for example, with the category of 'spiritual but not religious'—a stance we fully recognize—we are employing a broad, encompassing conceptualization of religion as shorthand to include individual, organizational, and societal expressions. Importantly, religion as a social category must be understood as intersecting with other social classifications such as gender, class, sexual orientation, and race (Reimer-Kirkham & Sharma, 2011, 2012). Applying intersectional theory to religion sheds light on how religion operates in tandem with these other influences in identity formation, and also as operative in social relations of power to disadvantage and advantage, to oppress and liberate. In this article, the ambivalences of religion are evident in the marginalization that occurred at times on account of women's religious identities. And yet their religious convictions could also provide forms of social capital.

Religion is increasingly viewed as a transnational phenomenon. No expression of religion—whether institutionalized or personalized—can be understood as anything but globalized, albeit particularized and contextualized. Although religion exists within individual interpretations in local communities and is distinctively influenced by a national cultural and political context, it is inextricably connected with the wider world and is influenced by these relations. As explained by Wuthnow and Offutt (2008), transnational religious connections consist of actual flows of people, goods, services, and information across national boundaries, facilitated by transnational organizations and by broader trends in the global political economy.

Clearly, the globalized nature of religion must be recognized as a historical continuity rather than only a contemporary phenomenon. Itinerant Buddhist monks traveling to China and Japan, French priests in Canada known as "New England" and Spanish and Portuguese priests in South America during the colonial era are early examples of transnational religion. Grypma (2007) documents the involvement of Canadian missionary nurses in China before the turn of the 20th century explaining that "a religious 'awakening' of thousands of young