"DISEASE BREEDERS AMONG US" CANADIAN PRESS COVERAGE OF IMMIGRANT TUBERCULOSIS: A CRITICAL DISCOURSE ANALYSIS

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By

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A thesis submitted to the School of Graduate Studies

in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Division of Community Health & Humanities

Faculty of Medicine

Memorial University of Newfoundland

September 2010

St. John's, Newfoundland & Labrador

Yet in every continent, under every climate, and among men of every race, there are communities where tuberculosis is either completely absent or of little consequence; in fact, the disease has been practically wiped out from a few localities where it was once prevalent. Clearly, then, its destructive power is not the inevitable expression of geographic, climatic or racial factors.

René and Jean Dubos, 1996, p.xxxvii

Abstract

Since 1987 the highest proportion of tuberculosis (TB) in Canada is associated with immigrants. This high burden is typically linked in the public health literature to country of birth, low education, and various barriers to primary care. The role of poverty and material deprivation in the etiology of immigrant TB is understated. Racializing TB and its carriers highlights the dual focus of TB control: guarding the health of the nation at the borders by excluding the sick and by monitoring of those immigrants already in the country. By neglecting social determinants of immigrant TB and reasons for their unequal distribution, the current TB control policies perpetuate the high burden of TB in the immigrant population.

The racializing character of these policies is grounded in discourse about "inherently inferior and diseased" immigrants' bodies, which was central to the development of TB control in Canada at the beginning of twentieth century. In this work I critically examine the discourses about immigrant TB that were (re)produced by the Canadian press. I look at the relationship between the (re)produced discourses and the current TB control policies, and also at the historical, political and socio-cultural context in which particular newspaper discourses were rooted and reproduced. In this work, I demonstrate that the racializing discourse continues to be (re)produced by the Canadian press. In this way, the Canadian press reinforces the racializing character of current immigrant TB control. In this work, I call for the implementation of TB control policies which would address social determinants of immigrant TB and for fair and balanced reporting on immigrants' health affairs.

Acknowledgements

First, I would like to thank God, the Most Gracious and the Most Merciful, for His countless blessings which have allowed me to seek knowledge and pursue my studies at the doctoral level—an opportunity that millions sharing this planet with me do not have.

Second, I am very grateful and indebted to my mentor and supervisor, Dr. Diana Gustafson, for her tireless guidance of my first timid steps through public health theory and research until the accomplishment of this level of academic work, for the excellence of her many ideas to improve my research, for the time she dedicated to all my academic and personal inquiries, for the generosity and humility with which she shares her knowledge with me, for her support, encouragement and kindness, for her belief in me and her enrichment of both my academic and my personal life by showing me that there are many perspectives from which to view this world.

Third, I am very thankful to my supervisory committee members, Dr. Fern Brunger and Dr. Cathy Donovan, for sharing with me their valuable time and knowledge, for providing me with helpful comments and for supporting me throughout the course of this work. Many thanks belong to Dr. Jennifer Connor for her useful advice on historical aspects of this research project and to Dr. James Valcour for his kind assistance with a table design.

I also wish to acknowledge the Division of Community Health and Humanities at Memorial University of Newfoundland for its logistical support throughout my work and

the faculty and students who enriched my ideas in numerous thoughtful discussions. A special thanks is due to Mrs. Sandra Meadus for all the secretarial and administrative assistance with which she has always generously provided me and to Mrs. Irene Sheppard for her impressive proofreading and copyediting, which greatly improved the readability of my work.

Finally, I must extend a special appreciation and expression of gratitude to my husband, Mohamed. I would never have been able to finalize this work without his presence, support, courage, love and care. His insightful critical comments also shaped the way I present my work today. I am also endlessly thankful to my children, Yousuf, Hana and Tayyib for their hugs, kisses, and gentle smiles, which have always inspired me to continue my fight for human rights and justice in the health field. I would also like to express my sincere gratitude to my parents and family for their love, support and encouragement. I must credit them with the lion's share of the motivational interest which prompted this work, since it is a reflection of the care with which they raised me. I also thank my husband's parents for their kind and lasting support.

I am also grateful to all my friends living nearby and overseas for their words of encouragement in the course of my studies, but especially to my dear friend Houda El Sayed who, despite her own difficulties, provided me with many opportunities to dedicate time to my work by taking care of my daughter.

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List of Abbreviations

AB	Alberta
BC	British Columbia
CBC	Canadian Broadcasting Corporation
CDC	Centers for Disease Control & Prevention
CH	Chronicle Herald
CIC	Citizenship and Immigration Canada
CNA	Canadian Newspaper Association
CPHI	Canadian Institute for Health Information
CSIS	Canadian Security Intelligence Service
DOT	Directly observed therapy
EJ	Edmonton Journal
FBI	Federal Bureau of Investigation
GM	Globe and Mail
HIV/AIDS	Human immunodeficiency virus/Acquired immunodeficiency syndrome
MB	Manitoba
MG	Montreal Gazette
MP	Member of Parliament
NADbank	Newspaper Audience Databank
NDP	New Democratic Party
NGO	Non-governmental organization
NP	National Post

NS	Nova Scotia
OC	Ottawa Citizen
ON	Ontario
OS	Ottawa Sun
PHAC	Public Health Association of Canada
QC	Quebec
RCMP	Royal Canadian Mounted Police
SARS	Severe acute respiratory syndrome
TB	Tuberculosis
TS	Toronto Star
TST	Tuberculin skin test
UK	United Kingdom
USA	United States of America
VS	Vancouver Sun
WB	World Bank
WFP	Winnipeg Free Press
WHO	World Health Organization
XDR	Extensive drug resistance

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Chapter 1

Introduction

1.1 Problem statement

> *Not only is a health care system a product of a country's history and culture, but it is also instrumental in constructing nation by shaping identities and experiences, institutions and policies, oppressions and inequities.*
>
> Anderson & Reimer Kirkham (1998, p.251)

In Canada's colonial history the oppression and marginalization of people of non-European non-white background was present in all spheres of life (McLaren, 1990; Ward, 2002). Racist ideologies which facilitated this discrimination are morally wrong and scientifically incorrect, however, they persist because "the *fundamental structures* of society have not changed so as to be inclusive and representative of the different groups that make up Canada" [emphasis in original] (Anderson & Reimer Kirkham, 1998, p.251). The healthcare system is one of these institutions which, according to Anderson and Reimer Kirkham (1998), remained Eurocentric and classist and therefore exclusionary and inaccessible to many people of colour. Consequently, many ethnic and cultural minorities experience poorer health outcomes and inequalities in access to health services when compared to other populations (Hyman, 2009; Johnstone & Kanitsaki, 2009; Klonoff, 2009). These inequalities are often racialized, which means that poor health outcomes and service access are often blamed on differences in biology, health

behaviours or health choices of minoritized groups.[1] Discriminatory institutional structures, policies and operations are rarely seen as the reason for these inequalities because racism "ha[s] been codified in our institutions of custom, practice, and law" (Jones, 2000, p. 1212) and internalized by people as common sense and unquestioned daily experiences (Essed, 1991).

In this thesis, I argue that current TB control policies are an example of institutional racism which perpetuates the uneven distribution of TB in Canada with the highest burden carried by the immigrant population. I maintain that current policies are ineffective in TB prevention within some segments of the immigrant population because they fail to address important environmental factors (social, economic and political). This makes some immigrants vulnerable to developing TB several years after migrating to Canada. These policies which are based primarily on screening and surveillance do not address or take into account the causal relationship between poverty and deprivation that contributes to the reactivation of TB within some segments of the immigrant population (WHO, 2005).

In Canada many immigrants live in disadvantaged neighbourhoods with poor housing standards, limited access to sustained full time employment and an insufficient household income to ensure adequate nutrition (Fleury, 2007; Hay, Varga-Toth & Hines, 2006; Hyman, 2009; Kazemipur & Halli, 1997). Immigrants' access to health and social services is also limited. As a result of this socio-economic background, the proportion of TB cases associated with immigrants has increased from 35% to 66% between 1980 and

[1] The term racialized is different from that of racist which means discriminatory based on one's race, ethnicity or culture

2007 (Public Health Agency of Canada (PHAC), 2008a).[2] However, the high burden of TB among immigrant populations is typically linked in the public health literature to country of birth, low education, and economic, cultural and linguistic barriers to primary care (PHAC, 2008a; Wobeser, Yuan, Naus, Corey, Edelson, Heywood et al., 2000). The risk factors such as low education and economic barriers to primary care do not account for poverty; rather they indicate that immigrants do not have either enough knowledge or sufficient finances to adhere to screening and prophylactic treatment. Literature typically does not speak about poverty-related conditions of immigrant lives such as malnutrition and overcrowded substandard housing. It also does not address the reasons of immigrant poverty such as discrimination. Welshman and Bashford (2006) stated that such TB control policies which focus primarily on pre-entry screening and post-migratory surveillance "are more about migration and asylum politics rather than public health" (p.284).

The absence of policies which address socio-economic and political causes of TB of immigrants can be explained by cultural and political factors which, refracted through science and medicine, were central to the development of TB control in Canada. Screening and surveillance policies are rooted in the historic and ideological context of fears of contagious diseased immigrants that permeated the Canadian society at the beginning of twentieth century. While these policies emerged from the belief that immigrants with TB had "inferior" genes (Devereux, 2005; McCuaig, 1999; McLaren, 1990), current policies reinforce the belief that the TB problem is related primarily to

[2] More detailed statistics including the data on Canadian population are provided in chapter 3.

immigrants' country of origin. In both eras the link between TB and the post-migration experience of poverty remains overlooked. Some theorists attribute this to the limited political power and resources available to immigrants to confront systemic discrimination and institutionalized racism (Anderson & Reimer Kirkham, 1998; Gandy & Zumla, 2003; Reitmanova & Gustafson 2008; Young, 1990). Others point to the powerful discourses of the sick and contagious immigrants reproduced in both scientific and public realms (Bell, Brown & Faire, 2006; Eichelberger, 2007; Ho, 2003; Lawrence, Kearns, Park, Bryder & Worth, 2008; Littleton, Park, Thornley, Anderson & Lawrence, 2008; Murdocca, 2003; van Dijk, 2001; Washer, 2004).

This thesis explores these explanations, examining the institutionalization of racism in TB public health control and the (re)production of racialized discourses of immigrant TB through the contemporary Canadian press. The next section explains in more detail the methods through which this purpose and objectives will be achieved.

1.2 Study purpose, objectives and methods

> *Discourse analysis aims to show how the cognitive, social, historical, cultural, or political contexts of language use and communication impinge on the contents, meanings, structures or strategies of text or dialogue, and vice versa, how discourse itself is an integral part of and contributes to the structures of these contexts.*
>
> van Dijk (1991, p.45)

The purpose of this work was to use critical discourse analysis and descriptive statistics to critically examine:

1. the discourses about immigrant health that were (re)produced by the Canadian press through its coverage of immigrant TB,

2. the relationship between the (re)produced discourses and TB management policies adopted by public health authorities and healthcare providers in Canada, and also
3. the historical, political and socio-cultural context in which particular newspaper discourses were rooted and reproduced.

Willig (1999) defined discourse as "a loose network of terms of reference which constructs a particular version of events and which positions subjects in relation to these events" (p.160). Hence, I searched in communicated messages for a "hidden layer of signification lying beneath the obvious, taken-for-granted surface" (Lupton, 1992, p.147). First, I examined the content of stories through the employed macro-elements which "represent what news-makers construe to be the most important information about a news event" (van Dijk, 1991, p.71). Then I examined the ways in which textual macro-elements (such as topics and themes) and narrative structures (such as characters and plots) "'invite' readers to actively and imaginatively decode the contents of the story, subjectively making sense of and attributing meaning to its message" (Hier & Greenberg, 2002, p.495). Finally, I related the identified narrative structures "to various properties of the social, political or cultural context in which they take place" (Lupton, 1992, p.145). I did not simply describe discourses but I located them in relation to social structures and interactions.

Identifying interpretative-narrative patterns in text, while important, is insufficient to characterize discursive analysis as *critical*. Locke (2004) explained that the aim of a critical analytical approach is not "to reveal some sinister and manipulative hand aiming

to impose power over others, but to provide opportunities for critical detachment and review of the ways in which discourses act to pervade and construct our textual and social practices" (p.89). Using this critical approach may uncover the (re)production of dominant ideologies buried within discourse, and serve as a tool for critique and/or to call for a change in the status quo (Lupton, 1992).

Although critical discourse analysis is an important tool in identifying and addressing dominant social and political powers, ideologies and myths, it has several limitations. First, it relies "almost entirely upon the particular scholar's reading of a text, with little regard for how others, especially those of a different class, ethnicity, age or gender might interpret the same text" (Lupton, 1992, p.148). I acknowledge that my personal background (being an immigrant schooled in medicine and public health) and research standpoint (critical feminist anti-oppression perspective) impact on my textual interpretation. To validate my interpretations I made extensive use of the actual text examples and identified all macro-elements which I logically connected to a broader social, political or historical context (Lupton, 1992). During analysis I tried to avoid under-analyzing the text by superficially summarizing the data or by over-quotation and/or taking sides in the interpretation (Antaki, Billig, Edwards & Potter, 2003). I also avoided selectively choosing only those parts of texts that supported my assumptions and included also those examples that contradicted these assumptions. I assumed that the Canadian press coverage might share the commonalities with other international studies that investigated the media coverage of immigrant issues in the West. I shall return to describing these commonalities later in this chapter. To increase the validity of my

interpretations I also avoided over-generalizing (Antaki et al., 2003). My findings are not generalizable to other countries since their colonial histories, patterns of immigration and prevalence of immigrant TB may be different than those of Canada.

Furthermore, scholars are advised to compare their interpretations with other scholars and also to seek constructive feedback from their audiences because "the reader has understandings about aspects of the society in general, and is well placed to see whether the discourse works in the context of the big picture" (Stevenson, 2004, p.27). Therefore I compared my reasoning with other scholarly works. I also presented some preliminary results of this work in journals and at conferences and seminars (see Appendix 1).

To strengthen their arguments, researchers can further support their qualitative analysis with "quantitative evidence on the prevalence and patterns of message occurrence" (Neuendorf, 2004, p.35). For this purpose, I generated the frequency of topics, themes, significant words and statements that emerged from the analyzed articles, and organized the results of the quantitative analysis into the tables that accompany my interpretations. These descriptive statistics were important in supporting my understanding that the (re)production of particular discourses in media is shaped by racist ideologies since they quantified the amount of the produced discourses. If a particular racist discourse occurs in 75% of the chosen newspaper articles, then it is reasonable to conclude that this discourse did not appear in the news just as a single opinion of a few journalists. In that case this percentage indicates that the discourse producers operate under specific assumptions and beliefs about the issue of immigrant TB in Canada.

As is typical of other types of qualitative research, discourse analysis is not concerned with supporting a pre-specified hypothesis. As Stevenson (2004) put it, discourse analysts "are interested in looking at a range of responses and how they are organized in everyday life situations" (p.22). In order to achieve this objective, he suggested following the three steps commonly used by discourse analysts:

1. Identification of the text to be examined
2. Review of the text-relevant theoretical and methodological literature
3. Identification of the approaches helpful in reading and interpreting the text

Step 1: I studied the coverage of immigrant TB in the news, editorials, columns and letters to the editor in 273 selected articles of ten major Canadian daily newspapers published between January 1, 1999, and December 31, 2008. I selected the English daily newspapers with the highest circulation and a range of political leanings which were published in the seven cities identified as the most influential in news production in Canada: Ottawa, Toronto, Montreal, Vancouver, Edmonton, Winnipeg, and Halifax (Kariel & Rosenvall, 1995). I provide details about the texts I examined and the criteria that guided my selection in Chapter 5.

Step 2: I reviewed the relevant theoretical and methodological literature about racism, reproduction of ideology, and discursive media practice (presented in Chapters 2, 3, and 4). The theoretical information was reviewed in light of the historic representation of immigrants in Canada. To borrow from Miles (1989): "I do not claim to offer a comprehensive analysis of western representations of the Other, only significant

instances which illustrate [my] stated objectives....any systematic analysis would require a text longer, and very different, from what is offered here" (p.13-14). Hence, many of my examples were drawn from British colonialism and the historic period of Canada's nation-building at the turn of nineteenth and twentieth century. This historical period was the key time frame for my review because colonialist images of race were formulated and solidified at that time.

I also provided examples of contemporary representations of immigrants. Briefly, works of discourse analysts engaged in the field of media representation of immigrants indicate that the current coverage is dominated by several discursive areas which are historically rooted and politically linked to the long-standing ideologies of racism and nationhood (Bell et al., 2006; Eichelberger, 2007; Greenberg, 2000; Henry & Tator, 2002; Hier & Greenberg, 2002; Murdocca, 2003; van Dijk, 2001, 1999, 1996, 1991; ter Wal, 2002; Washer, 2004). These authors identified the following tendencies to negative representation of immigrants and other minorities and their affairs which retrospectively validate and (re)produce the historic racist ideologies:

a. Immigrants are often portrayed in the media as posing a threat to the health of the local population of their recipient countries (Bell et al., 2006; Eichelberger, 2007; Washer, 2004). The incidents of their ill health are often racialized (associated with the country of their origin, race, ethnicity or culture), while the social context in which their health and post-migration experience are embedded is often ignored (Greenberg, 2000; Leung & Guan, 2004; Murdocca, 2003).

b. Immigrants are variously described as "imposters, scroungers, or otherwise represented as negative" and often associated with "specific forms of 'ethnic' crime, such as aggression, mugging, rioting, theft, prostitution, and especially drugs" (Henry & Tator, 2002; van Dijk, 2001, p.309).

c. Immigration is a serious problem, a threat, an invasion, or a crisis but seldom "a welcome contribution to ethnic and cultural diversity, the economy, and the demography" of the West (ter Wal, 2002; van Dijk, 2001, p.309).

d. The coverage of daily experiences of minorities and their problems such as housing, employment, health and discrimination is very limited (Henry & Tator, 2002; ter Wal, 2002).

e. The coverage employs a so-called deficit model of culture according to which minorities are portrayed as if they are constantly in need and a discourse of capitalist free enterprise according to which they should "pull themselves up" to achieve success as other members of society (Locke, 2004).

f. The coverage of immigrant women often utilizes the discourse of domesticity in which "the presence of immigrant women is evoked under the notion of family, maternity and reproduction with scarce recognition of feminine individuality" (Nash, 2006, p.58). Racializing women's cultural differences places immigrant women in rigid stereotypes which disallow viewing their personal and collective development within the social dynamics. If visible, immigrant women have, at times, been associated with abuse, violence, and prostitution (Nash, 2006). While immigrant mothers have been portrayed as

symbols of cultural tradition – even backward – and a drain on state resources, young women have been represented as victims of or rebels against cultural traditions of their families (Raissiguier, 2003). These discourses are especially evident in controversial and politicized discussions of polygamy, forced marriages, female genital mutilation and the wearing of head scarves.

As for the coverage of immigrant TB, there were no published Canadian studies of media representation at the time I undertook this study. Two studies that exist elsewhere, one conducted in the UK (Bell et al., 2006) and one in New Zealand (Lawrence et al., 2008), found the following commonalities:

a. TB was presented as a feared foreign disease imported by immigrants thus focusing on immigrants' origin, race and nationality. There was no analysis of the social and economic context responsible for the higher burden of TB in this population.
b. Newspapers failed to recognize the heterogeneity and differences that existed among diverse immigrant groups, thus obscuring the underlying causes of TB.
c. The problem of TB triggered calls from politicians and the public for the government to tighten border control as the main solution to the health threats immigrants supposedly posed to their respective host nations.
d. Newspapers ignored the commonalities in the distribution and experiences of TB among immigrants and other marginalized groups in the UK and New Zealand, commonalities that may have informed policy decision makers about

the need for policies that addressed the social and economic determinants of health.

Step 3: After reviewing the text-relevant literature, I described the textual macro-elements (subjects and topics) of the dominant discourses about immigrant body and health underlying the news and stories of immigrant TB that appeared in the selected news items. Then I connected the identified macro-elements to a broader social, political or historical context. I compared the identified discourses with the findings of other discourse analysts. Finally, from my findings I made conclusions about the role of (re)production of media discourses in maintaining institutional racism in the Canadian healthcare system and about the role of existing power relationships in shaping production of media discourses about immigrants.

1.3 Key concepts

Prior to discussing the issues relevant to the rationale of this thesis, my use and understanding of several terms must be clarified. This study examines the press discourses of TB of immigrants in Canada. I use the term *immigrant* to refer to any person born outside Canada who came to Canada as an immigrant regardless of his or her current immigration or citizenship status. The agencies such as Statistics Canada and Citizenship & Immigration Canada (CIC) include in the category "immigrant" individuals who were born outside Canada but who have since gained their Canadian citizenship. Therefore according to these agencies, a person who came once to Canada as an immigrant is always considered an immigrant, regardless of citizenship.

In 2006, there were 6,186,950 immigrants residing in Canada, which represents about 21% of the total population (Statistics Canada, 2007). The largest immigrant populations lived in Ontario, Quebec, British Columbia and Alberta. According to CIC (2009), 230,000 immigrants on average have entered Canada every year in the past decade. Approximately 60% of these immigrants were *economic migrants* (skilled workers, business immigrants and live-in caregivers) who were awarded immigration visas based on their education, work experience, knowledge of English and/or French, and their potential to become economically established in Canada. Spouses and family members of the economic migrants (*family class)* accounted for 27% of the immigrants.

The *refugee* population represented 9% of the admitted immigrants. About 4% of immigrants were *humanitarian cases* and *other immigrants*. Distinguishing among these categories of immigrants is important since there are different TB control policies (explained later on in Chapter 3) that apply to economic migrants (and their families) and to those who arrive in Canada as refugees.

While historically, most Canadian immigrants were from Europe and the USA, in the past two decades Canada has witnessed a major shift in this trend and majority of immigrants come from the other geographic regions. In 2008, about 53% (out of 247,243) immigrants to Canada were from Asia and the Pacific; 14% were of African and Middle Eastern origin (CIC, 2009). While European immigrants accounted for 14%, about 12% of immigrants came from South and Central America and only 7% came from the USA (see Figure 1.1). The five languages spoken by immigrants in rank order were English, Mandarin, Arabic, Tagalog and Spanish. According to Census 2006, 54% of

(3,362,150/6,186,950) immigrants identified themselves as visible minorities (Statistics Canada, 2007). Because the majority of recent immigrants belong among visible minorities, my critical literature review logically focuses on the issue of race definition and its practical implications.

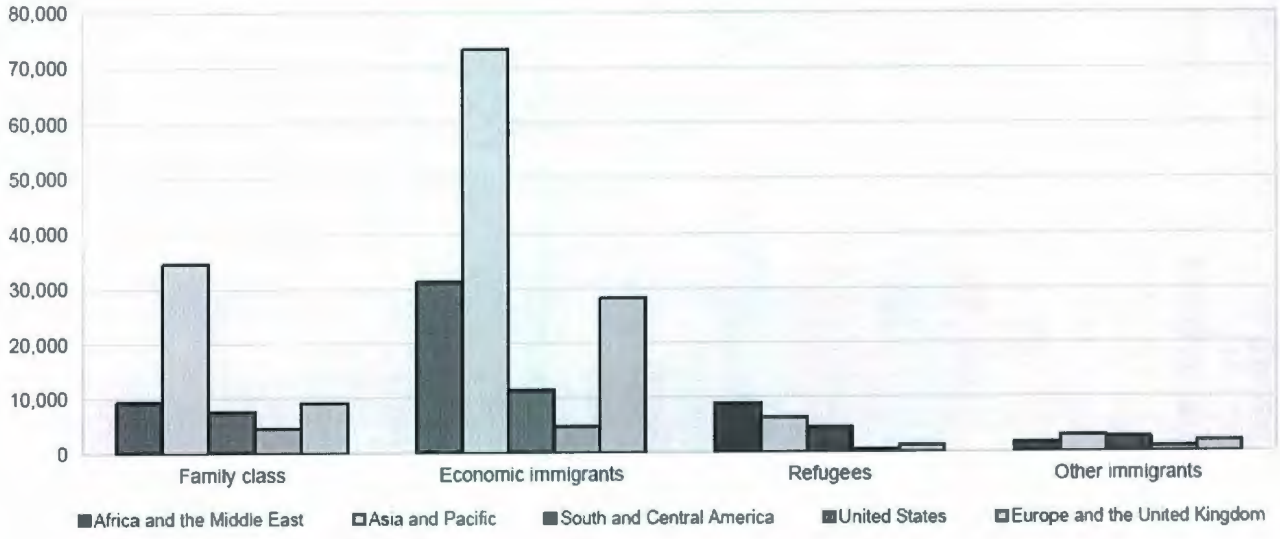

Figure 1.1: Immigrants by category and source area in 2008 (CIC, 2009, p.18)

Visible minorities in Canada are defined by the *Employment Equity Act* as persons who are non-Caucasian or non-white in colour. In my thesis I adopted this definition of visible minorities, although, I do recognize that the term visible minority is contentious for several reasons. First, in the government's narrow understanding only a person's non-white skin colour and non-European origin are markers of one's visible minority status. It means that, for instance, white European practicing Muslim women from Bosnia are not considered visible minorities, although their dress and lifeways make them noticeably

different from the mainstream and often an object of differential treatment (Colic-Peisker, 2005).

Second, who belongs to the visible minority category can change with time. Some groups which were classified as visible minorities in the past such as Irish, Italian and Jewish immigrants are not racialized anymore. These groups were "whitened" and promoted to the ranks of "model middle-class white suburban citizens" (Brodkin, 2007, p.293).

Third, the current use of the term "minority" suggests that what matters is the quantity of people. In government's understanding minority assumes that the size of non-Caucasian non-white population is smaller than the number of their Caucasian white counterparts. However critical culture theorists regard as visible minorities all groups of people who occupy low levels in social hierarchy in terms of their power, privilege, access and prestige (Avery 1995; Das Gupta, James, Maaka, Galabuzi & Andersen, 2007; Henry & Tator, 2000; Strong-Boag, 1998). I agree with this position and realize that visible minorities born in Canada also experience racialization of their health and social problems (Spitzer, 2005a). However, for the purpose of this project I focus on the experiences of the immigrant population only.

Because the majority of recent immigrants belong to visible minorities in terms of their skin colour and origin, many occupy inferior social positions in Canadian society. Using the common word *immigrant* has therefore one important disadvantage: it creates a false impression that immigrants represent a homogenous group and obscures the differences in their post-migration experience (Gustafson, 2008). The existing

inequalities between different immigrant groups facilitate my understanding that "immigrants and minorities are not a monolithic group. Therefore, immigrant or minority groups should be assessed separately to direct group-specific policies for improving health outcomes and patient satisfaction through the provision of equitable, effective and efficient health care" (Aroian, 2005, p.105). For this reason, when I speak of immigrants' inequalities, discrimination, poverty or their negative representation, I mean those groups of immigrants whose skin colour, culture, ethnicity or religion are deemed and treated as inferior in socially stratified society.

I recognize that there are many similarities in the articulation and use of the socially-constructed categories of culture and ethnicity as both refer to group membership, belonging and identity. Whilst both are fluid terms that reflect a process "being negotiated and constructed in everyday living" (Isajiw, 1993, p.4) there is a difference between the two. Ethnicity has two dimensions or aspects. The objective aspects include the existence of community institutions such as schools, churches and media, the relations of kinship, descent and ethnic personal networks as well as the existence of a "script" for cultural behaviour which include speaking an ethnic language or practicing traditions (Isajiw, 1993). The subjective aspects include attitudes, values and preconceptions of individuals which operate as self-identification mechanisms and also as socio-psychological boundaries of inclusion/exclusion of individual into ethnic groups (Isajiw, 1993). The term ethnic group refers to "a community-type group of people who share the same culture or to descendants of such people who may not share this culture but who identify themselves with this ancestral group" (Isajiw, 1993, p.6).

Culture is conceived as a composite of "deeply interconnected social and political categories" of nationality, skin colour, religion, gender, sex, age, ability or citizenship (to name some) to which people attach a variety of positive, negative or neutral meanings (Gustafson, 2008, p.48). Rather than a fixed set of beliefs, values and practices passed between generations, culture reflects a unique historical group experience (Isajiw, 1993) which is constantly in flux and can change according to political climate, restructuring of neighborhoods, and patterns of immigration (Boutin-Foster, Foster & Konopasek, 2008).

People who occupy higher levels on the social ladder in terms of power, privilege and prestige are considered the dominant forces. Due to historic and political circumstances dominant groups of people in western societies like Canada happen to be by default "white, male, heterosexual, middle-class, politically 'moderate' (that is, more or less conservative)" (van Dijk, 1995, p. 29) and Christian (Coleman, 2006). White dominance refers to the power of the dominant group integrated in laws, rules, norms, habits, and in a general consensus which grant all whites unearned privileges to which non-whites are not entitled (Day, 2000). This form of power is called hegemony (Gramsci, 1971). Because of this hegemonic power, the dominant white group in Canada does not need to be concerned about their misrepresentation because

> a corrupt Anglo-Canadian politician is not perceived as stigmatizing an entire Anglo-Canadian community; financial scandals are not seen as a negative reflection on White power, the lack of success of a White child in the educational system is not assessed in the context of the cultural deficits of the entire White community; and a crime committed by an individual of British or Italian origin does not generate any discussion about deportation to the United Kingdom or Italy (Henry & Tator, 2002, p.28).

In addition to the institutionalized hegemonic power, non-whites have considerably lower access to resources such as money, status, and education than many white people do. These resources then allow some white people to produce knowledge through public discourse and thereby define the representation of those who do not have similar access (van Dijk, 2001). This public discourse is difficult to challenge since it is produced by scholars, experts, professionals, or reliable media which are seen as authoritative, trustworthy, or credible sources. Their opinions and evaluations make the described interpretations of events credible because the power shapes whose knowledge has the authority (Said, 2003). I shall return to the topic of the persuasive power of media in Chapter 4.

I understand that not all whites share the same power, privileges and prestige. There are many oppressed groups of white people such as women, the elderly, people of different sexual orientation, and people with mental illness or physical impairments among others. They all "suffer some inhibition of their ability to develop and exercise their capacities and express their needs, thoughts and feelings. In that abstract sense all oppressed people face a common condition" and any discussion "about whose oppression is more fundamental or more grave" is fruitless (Young, 1990, p.40). Class domination, sexism, and ableism are all typical examples of hegemony as is racism (Razack, 1998; van Dijk, 2001).

In addition, I recognize that not all whites have negative attitudes towards non-white minorities but, as van Dijk (1991) noted, a few communist mayors, ministers, or professors does not turn the capitalist system to communism. For all the above mentioned

reasons, scholars continue to use the terms *white*, *Anglo* or *mainstream* when referring to the dominant group in Canada (Avery, 1995; Chapman, 1977; Coleman, 2006; Das Gupta et al. 2007; Day, 2000; Gustafson, 2007; Henry & Tator, 2000; Hughes & Kallen, 1974; Razack, 1998) and I adopted the language of these scholars in this work.

When referring to the distribution of poverty and TB among various WHO regions, I prefer to use the term *low-income countries* instead of *developing world*, *Third World* or *Global South* and the term *high-income countries* instead of *developed world*, *First World* or *Global North*. The classification of a country as a low-, middle- and high-income country according to its gross national income per capita was developed by the *World Bank* (WB). In 2008, gross national income per capita in low-income countries was $975 or less; in middle-income countries $976 - $11,905; and in high-income countries $11,906 or more (WB, n.d.). In my opinion, the division of countries based on the income factor illustrates the uneven distribution of the TB burden in the world better than the use of terms such as *developing* and *developed* which may "imply that all economies in the group are experiencing similar development or that other economies have reached a preferred or final stage of development" (WB, n.d).

The other terms for low-income countries also have several disadvantages. The term *Third World* was coined by economist Alfred Sauvy in an article in the August 14, 1952, issue of the French magazine *L'Observateur*. During the Cold War, many nations adopted this term to describe themselves as being aligned with neither the *First World* (represented by the US, its allies and NATO) nor with the *Second World* (represented by the East bloc and the Warsaw Pact countries). The term *Third World* originally meant

one-third of the world rather than the third in rank. However, over time, as the former European colonies gained independence and suffered the consequences of colonial and post-colonial economic exploitation, the understanding of the term Third World changed. Currently, it refers to three-quarters of humanity occupying two-thirds of the earth surface. It accrued a meaning of inferiority which implies "crying children with big sad eyes and empty bowels; people slowly poisoning themselves by eating and drinking from lands and waters contaminated by toxins from multinational industrial corporations; warfare between neighbors; people dying of curable ailments because of the lack of healthcare" (Vitello, 1993 as cited in Vogeller., n.d., ¶2). In addition, this term obscures the fact that profound inequalities exist among and within the countries regarded as Third World countries, just as they exist within high-income countries.

The terms *Global North* and *Global South* are also problematic. For instance, Western and Eastern Europe are both regarded as part of the richer Global North; however, there are great differences in economies and in the burden of TB experienced by the individual countries in these regions (WHO, 2009). There is also contention with several places (like the Persian Gulf or Turkey) as to where they belong in this categorization. Moreover, the terms are geographically confusing, since countries such as Australia and New Zealand are regarded as North, even though they are located in the southern hemisphere. Similar problems exist with the use of the terms *western* and the *West*. However, I chose this term as it is well-established in social sciences literature on the construction of discourses about racial ordering. I use these two terms to refer to the

cultures and peoples of Europe, North America, Australia, New Zealand, and South Africa.

1.4 Study rationale and contributions

Words do sometimes kill.

Van Dijk (1999, p.309)

I believe that uncovering and identifying the discourses underlying media reports is an important practice for several reasons. Identifying the misrepresentation can help uncover powers, interests and ideologies which underlie *mystification* of illnesses (Good, 1994) such as immigrant TB. The misrepresentation of immigrant health issues may wrongfully reinforce health policies that racialize and medicalize the problems surrounding immigrant post-migration experience and its impact on immigrants' health status and thereby bolster the health and social inequalities that some Canadian immigrants already experience (Hyman, 2007). In this way, my work contributes to a better understanding of how cultural production in media determines the health of marginalized populations such as visible minority immigrants. Anderson & Reimer Kirkham (1998) explain that "unless we recognize and unmask the unquestioned and taken-for-granted notions that are embedded in our institutions, health reform may build on the ideological structures that form the substratum of our current theorizing, policy decisions, and healthcare practices" (p.249). They further warn that "[w]ere this to happen, we would fail to address some of the very issues that might have been the impetus for health reform" (p.249). Such health reform efforts intend to remove health

inequities faced by minorities. In other words, in order to eliminate institutional racism in healthcare and reduce its negative impact on people's health, researchers must strive to expose and identify those oppressive health care structures, practices and policies which disadvantage, exclude and marginalize certain groups of people.

Uncovering media-constructed dimensions of risk perception regarding immigrant TB may inform policy makers about the true and imagined risks that immigrants exposed to infection pose to society as well as sharpen their focus on effective TB control and prevention. If social determinants of immigrant health (such as poverty, malnutrition, substandard housing and lack of services) remain unaddressed by health policies, then immigrants will continue to carry the highest burden of TB in the country. They will continue to be subjected to screening and surveillance as the only solution for *their* TB problem and the larger proportion of public health funds and efforts will continue to flow to narrow disease prevention interventions rather than to broad health promotion programs.

Additionally, newspapers provide their readers with an understanding of events and people about whom they do not have direct knowledge (Henry & Tator, 2002; van Dijk, 1991). They also serve as a powerful tool for forming political opinions and standpoints and can mobilize society to certain actions and interventions (Hier & Greenberg, 2002). Therefore, press coverage of immigrant problems and affairs that is negative or framed by racist anti-immigrant ideologies can foster negative opinions, attitudes and practices against this population (Henry & Tator, 2002; King, 2003). Such coverage can even kill, as van Dijk (1999) aptly articulated when linking the role of

media-enhanced Serbian nationalism with civil war in Bosnia and the role of radio with ethnic slaughter in Rwanda. Also Miles and Brown (2003) noted in a similar vein that it was the negative representation of specific social groups that once justified African slavery and the Jewish holocaust.

Some current studies have, in fact, documented that negative images of immigrants can promote fear and hatred within the native-born population and increase the existing social distance between a native and immigrant population (Eichelberger, 2007; Leung & Guan, 2004; Rack, 1988; Short & Magana, 2002). When immigrants adopt discrediting images, they may react aggressively to express their anger and frustration over the distorted messages, a result which will only lead to deeper alienation and exclusion of immigrants (Malewska-Peyre, 1993). Finally, persistent negative representation can lead to internalized racism when the stigmatized person or groups accept the negative messages about their intrinsic worth (Jones, 2000). Such persistent negative self-representation may include mistrust of the other members of the same group, suppressing one's aspirations, rights and self-expression. It can also manifest through attempts to become the "other", for example, by embracing whiteness through using bleaching creams (Hall, 1995; Hunter, 2007). Finally, internalized racism can lead to self-devaluation manifested by using racial slurs, rejection of ancestors or self-hate (Dobbins & Skillings, 2000). Resignation of one's "inferior" social status may then lead to drug abuse or criminality (Bowser & Bilal, 2001).

Social production and representation further significantly shape access by minorities to socio-cultural, economic and political power and determine social

stratification and hierarchy (Henry & Tator, 2002; Hughes & Kallen, 1974; van Dijk, 1995). As Robbins (2006) put it: "... membership in certain racial or ethnic groups [is] enough to place people in particular positions in the status hierarchy that defines their social, political and economic worth" (p.245). Therefore, uncovering misrepresentations can, in the long-run, improve minorities' access to resources and power.

Finally, critical discourse analysis that identifies racializing discourses and explains how these discourses contribute to the (re)production of racist ideologies can provide knowledge from which educators, media workers, public health policy makers and service providers – as well as the general public – can derive alternative discourses. With the new alternative discourses members of society "may vary or deviate from [system] principles and thereby challenge and eventually change the system – or even produce another [better and more inclusive] system" (van Dijk, 1991, p.34). Therefore, I believe that my work may contribute to an important debate on issues of diversity, inclusion, fairness, substantive equality, and tolerance of the immigrant population in Canada.

1.5 Thesis outline

In Chapter 2, I shed light on the roots of racism in Canada's immigration context by tracing its history to the period of European Enlightenment when the biological concept of race was born and scientifically framed. The second part of this chapter explains those mechanisms that maintain the racial hierarchy despite the legislative commitments of western countries to eliminate racial discrimination. Particular attention

is paid to institutional forms of racism which effectively institutionalize racial discrimination and reproduce social inequalities in western societies like Canada. In support of this, several examples of contemporary institutional racism in education, employment, healthcare and criminal justice systems are provided. Canada's multiculturalism policy is critiqued for its failure to address racism. Recent public surveys included at the end of the chapter support this assertion.

In Chapter 3, I offer biomedical and epidemiological explanations of the functioning and spread of TB. I outline current immigrant TB control public health policies in Canada. Then I move to a critique of these policies. I argue that these policies are rooted in the historic and ideological context of fears of contagious diseased immigrants, fears that permeated Canadian society at the beginning of twentieth century.

I then turn to the role that the press has played and continues to play in the (re)production of racist discourses. I begin Chapter 4 with a description of the advent of print media during the seventeenth century first in Europe and later in North America. I provide numerous examples of press representation of immigrants, to highlight the role that the Canadian press played and plays in constructing people's knowledge of immigrants as a "problem" and in mobilizing concerned citizens to design policies and enact solutions to deal with this supposed problem. In the second part of this chapter I present a theoretical framework of discursive media practice which provides a platform for the understanding of the past and present representations of immigrants in the Canadian press.

I then offer some relevant information about the selected newspaper articles. The first two sections of Chapter 5 identify the recruitment criteria that guided selection of the examined text and offer readers a brief background to the selected newspapers. The third and fourth sections provide statistical data on the status of immigration and TB in the provinces or cities from which the newspapers were selected. The fifth section of this chapter deals with the descriptive statistical data of the analyzed articles; specifically, it concerns news frequency, origin, flow and prominence of the selected publications. Finally, the authorship data are also provided. The findings are compared with other relevant studies.

In Chapter 6, I explore the content of discourses about TB, immigrants and their health that the Canadian press (re)produced in the past decade. I organize these discourses around four main categories: biomedical aspects of TB, consequences of immigrant TB, immigrant health, and solutions to immigrant TB. This is followed by a discussion about sources and quotations used in the analyzed text.

After summarizing the findings of the previous two chapters, I turn in Chapter 7 to a discussion of the relationship between the discourses identified in the press and the prevalent public health discourses of immigrant TB. I draw conclusions about how institutional racism in healthcare is reproduced through public discourse, how the existing power relationships shape the production of the identified discourses and how these discourses construct our knowledge about immigrants, in particular, their identities and their agendas. Based on these conclusions, I propose several important recommendations

directed at public health decision makers, service providers and journalists in Canada. Finally, I outline several directions for future research.

Chapter 2

Racism and society

> *To this end, the term racism is taken as referring to a highly political process of racial ordering and 'othering'... on the basis of a given people's language groups, religion, group habits, norms and customs... A key premise upon which this definition is based is that racism is fundamentally about power and, in particular, 'the ability to construct others as different in order to exclude or ignore or exploit them'*
>
> (Hollinsworth, 2006, p.252; Johnstone and Kanitsaki, 2008, n.p.)

Racism in Canada's immigration context has its historical roots in the period of European Enlightenment, a time when the biological concept of race was born and scientifically framed. The external physical differences exhibited by humans in different geographic regions were categorized into a hierarchy of races according to which the white European race was regarded as the ideal of human civility while all other races were deemed inferior, less civilized and even degenerate. The racial ordering played a significant role in the production of racist stereotypes and prejudice and systemic discrimination of certain groups of immigrants searching for new opportunities in Canada.

Although by the middle of twentieth century the biological concept of race was under scrutiny, the ordering of races (ethnicities, nationalities and cultures) still continues to be widely reflected in a variety of public discourses and profoundly impacts the life of those occupying the lower positions on the presumed racial ladder. Several mechanisms maintain this racial hierarchy today, despite the legislative commitments to

multiculturalism made by western countries such as Canada to address racial discrimination.

2.1 Race as biology: Roots of racism in Canada's immigration context

> *Our asylums, jails, hospitals and other charitable institutions show an increasing percentage of men and women, emigrants from the older lands, who are handicapped by a bad heredity, and quite unfit to make their way in the new world. Their children are equally unfit. They are underfed and undersized; they inherit unsound minds and diseased bodies of their parents and are doomed to suffering and inferiority form the very beginning of their lives.*
>
> (Knight 1907, cited in McLaren, 1990, p.52)

The 500-year-old word *race* used in the past to describe a set of persons, plants or animals with common features acquired a narrower meaning as the frequency of international travel increased and the physical differences among people became more apparent (Hughes & Kallen, 1974). The product of this new-found difference/strangeness between people was the concept of Otherness in which "the Other represent[ed] the unknown" (Lupton, 1999, p.129). People of western world produced numerous representations of *the unknown Other.* These representations were responsive to the ideological, social, cultural and political changes that were occurring in Europe at different historic epochs (Miles, 1989). During European Enlightenment of the eighteenth century, the image of *the Other* was redefined in new ways which powerfully shaped contemporary common-sense discourses of *the Other.*

In this historic era of Enlightenment, filled with fresh currents of thought, the foundations of modern science were laid down. New methods of scientific inquiry,

underpinned by the ideals of reason, rationality, order and regularity, were based on three fundamental assumptions: 1) science can describe the social world in universal causal laws, 2) human behaviour can be objectively measured and 3) social facts can be treated as things that determine human behaviour through norms (Clarke, 2004). In that milieu scientists tried to make sense of their observations by organizing them into categories and classes (Hughes & Kallen, 1974). Old terms such as species, subspecies and variety were re-used to classify and sort the world of plants and animals. Similarly, the observed differences between humans were sorted into taxonomic categories because it was widely believed that differences in people's appearances, qualities and abilities were biologically determined. As a result, they developed four broad biological subdivisions (races) which were "thought to be discrete, exclusive, permanent, and relatively homogenous" (Gravlee, 2009, p.48). Each racial subdivision was thought to share homogenous biological and socio-cultural characteristics which made each subdivision unique and distinct from the others (LaVeist, 1994). As I will demonstrate in Chapter 3, this new division by races had a strong value in medicine since scientists believed that the race played a significant role in etiology of many human diseases.

Carl von Linné, a Swedish scientist, classified humans into four specific categories based on people's physical differences and was the first to link different physical characteristics to distinct cultural, behavioural and moral traits. According to his classification in 1767, the red race (Native American) was, for instance, considered straightforward, eager and combative while the black race (African) was described as slow, relaxed and negligent. The yellow race (Asian) was regarded inflexible, severe and

acquisitive, and the white race (European) was deemed swift, clever and inventive. Other scientists modified and advanced Linné's classification, however, they maintained the same organizing principle – namely, the hierarchy of races (Hughes & Kallen, 1974).

According to this hierarchy, the white race was naturally and inherently superior to all other races, a belief which some scientists tried to demonstrate empirically by, for instance, measuring people's skulls (Lock, 1993). As Young explained:

> In scientific discourse about the normal and the deviant, the healthy and the degenerate, it was crucial that any form of degeneracy, whether physical, mental, or moral, make itself manifest in physical signs identifiable by the scientific gaze. Degeneracy was thought to appear on the surface of the body, whose beauty or ugliness was objectively measurable according to detailed characteristics of facial features, degree and kind of hair, skin color and complexion, shape of head, location of eyes, and structure of genitals, buttocks, hips, chest, and breasts. (1990, p.128)

Following this logic, all non-whites were easy to identify because of the ugliness and degeneracy they presumably exhibited. With the arrival of Mendel's laws of inheritance and Darwin's theory of evolution and natural selection, in the middle of nineteenth century, the racial hierarchy garnered increasing scientific legitimacy. At first, it was mainly biological differences which qualified the non-white races as degenerate, however, later when Darwin's followers linked biological and socio-cultural evolution together, the culture of non-whites also turned into an important marker of non-white inferiority and incivility (Hughes & Kallen, 1974).

The popularization of knowledge among lay masses was one of the ideals of the Age of Enlightenment: With this came the proliferation of scientific knowledge into the public realm (Headrick, 2000). Scientific academies and learned societies were eager to

share their findings and discoveries with public in coffeehouses (Cowan, 2005), lectures and public demonstrations (Headrick, 2000). With the advent of print media (travel books and newspapers) scientifically-justified discourses of racial hierarchy quickly entered the popular culture on a colossal scale. (I shall provide greater detail of this in Chapter 4).

By maintaining the ideology of racial ordering and the negative representation of *the Other* in both the scientific and public realms over several centuries, a non-white identity acquired a wide range of negative associations, connotations and meanings (Said, 2003). Non-whites were considered less civilized, dirty and inherently diseased. In Lupton's (1999) examination of risk that minorities pose to contemporary societies such as Canada, she reported that immigrants' "porous, odorous and damp" bodies were regarded as "potentially contaminating to those who came into contact with it" (p.131). Regarding non-white races as *the inferior Other* led to a notion that "these others could be civilized and that, indeed, the signs of European civility would be best demonstrated when those who were well advanced on the scale of modernity helped those who were less advanced to ascend the evolutionary ladder" (Coleman, 2006, p.12). This presumed need to civilize those not belonging to European geographic space was often used for justification of the European presence in its colonies and its consequent economic and political domination over those considered as "White Man's burden" (Hughes & Kallen, 1974, p.98).

Colonial beliefs that that non-white people were less civilized, even less human, are well documented. For instance, Thomas Babington Macaulay, president of Committee of Public Instruction in Bengal in 1834 reportedly stated that "a single shelf

of a good European library is worth the whole native literature of India and Arabia" (Anderson, 1991, p.86). Statements such as these justified calls to establish European educational systems outside Europe. This would ensure that non-white people would, despite their blood and skin colour, benefit from European education, even become European in their tastes, opinions, morals and intellect (Anderson, 1991).

The colonialist agenda and the ideology of racial hierarchy entered Canada with the arrival of white British settlers who came with the intention to build a new great colony – the last chance to save the greatness of British Empire (Coleman, 2006; Devereux, 2005). It was this ideology that caused the land dispossession and almost near extermination of Aboriginal peoples in Canada.[3] Subjection to the policies of exclusion and marginalization established and enacted by British settlers significantly changed Aboriginals' ways of life, culture and economic sustenance (Coleman, 2006). Thus, the Aboriginal population became the first victim of the ideology of racial hierarchy in North America. The second victims were those immigrants whose racial, ethnic or cultural identities were deemed undesirable in Canada. The more closely immigrants resembled the white British and the closer their country of origin was in geographic proximity to Britain, the more positive characteristics they were attributed (Woodsworth, 1972). On the contrary, those with "brown skins," "bad characters" and "peculiar customs," such as Chinese, Japanese and Hindus (defined at that time as Orientals) along with blacks and Aboriginals were considered, in Coleman's (2006) words, "incompatible with the national project of building of British-based civility" (p.22).

[3] It is estimated that up to 93% (105 million) of the Aboriginal population in the Americas was decimated within one century from the arrival of first European settlers (Coleman, 2006).

The anti-immigrant sentiments against the groups known as Orientals were well documented, as I will illustrate through numerous representations of Chinese people in Chapter 4. These representations often led to beliefs that "[Chinese] will never assimilate with the Anglo-Saxon race, nor is it desirable that they should.... They do not regard British Columbia as their home and when they die send their bones home to be buried in China" as documented in the *Report of the Royal Commission on Chinese Immigration* (Canadian Parliament, 1885, p.145). At that time immigrants from the whole of Asia were attributed the most negative features among all immigrants and were often seen as health and economic threats to Canadians. Woodsworth (1972) noted: "Whether it is in the best interests of Canada to allow them to enter in large numbers is a most important question, not only for the people of British Columbia, but for all Canadians" (p. 155).

The racist stereotypes led to attitudes and beliefs which equipped those on the top of racial and social hierarchy with feelings of superiority, feelings of intrinsic difference and alienation from subordinated groups, and finally, with feelings of proprietary claims of privilege and advantage (Blumer, 2004). These beliefs led those in positions of power and privilege to create institutional policies which reduced fair access to necessary resources and supports for some groups of immigrants upon their arrival to Canada. First, these policies imposed head taxes on those groups of people who were regarded as less desirable and inassimilable due "to their peculiar customs, habits, modes of life and methods of holding property" (Day, 2000, p.141). Second, some of these groups were banned from entering Canada by enacting the new immigration laws. For instance, due to

the restrictive immigration law from 1919, immigration from Asia was severely constrained till 1962 when a general entry requirement started to be applied.

Furthermore, some of those immigrants who were allowed to come to Canada were forced to live in extreme poverty, and work in harsh and dangerous conditions of construction and mining industry. In addition, they were often "denied the most basic and fundamental citizenship rights, including the right to work and live with dignity" (Mawani, 2003, p.4).

It must be noted here that a century ago southeastern European immigrants (such as Italians and Greeks) were racialized and faced similar discrimination to that of Asian immigrants. It was feared that these "beaten men of beaten races, – the worst failures in the struggle for existence" (Keane, cited in Chapman, 1977, p.13) would flood the country "with socialism, atheism and all other isms" and steal jobs from Canadian labourers (Avery, 1979, p.40). Their homes in ethnic ghettos were considered "a breeding ground for filth, immorality and crime" (Avery, 1979, p.41). They were characterized as being mentally degenerate and physically weak, as the quote by Queen's University's biology professor Knight from the beginning of this section suggests. However, southeastern Europeans were regarded as capable of being transformed "into good, intelligent citizens" (Magrath, 1909, cited in Coleman, 2006, p.12). This belief in the inherent potential of white southeastern Europeans materialized years later as many white immigrants assimilated into Canadian society and penetrated its social institutions while their non-white counterparts did not (Avery, 1995).

The *Immigration Act* of 1962 dropped the requirements that prevented people of certain race or origin to live in Canada. Since 1967, Canada has introduced a system of points which are assigned to immigrants based on their educational and work credentials, age, and knowledge of English or French rather than on racial signifiers (Canada in the Making, n.d.). However, critics of the new point-based immigration system assert that the assets of some immigrants continue to be valued more than the assets of others (Collins, 1996; Khayatt, 1994; Ng, 1992.). For instance, African immigrant women are awarded less points for their English fluency than British and Australian immigrant women because only the accent of African women is perceived as "foreign" by Canadian immigration officials (Creese & Kambere, 2003). Already disadvantaged by the admission process, non-white immigrants who have represented the majority of newcomers to Canada in the past two decades continue to experience social injustice in all spheres of life, as the following section will illustrate.

2.2 Race as politics and culture: Contemporary racism in Canada

Racism is like a Cadillac: there's a new model every year.

Malcolm X (as cited in Coleman, 2006, p.239)

In the middle of twentieth century 'the science' behind biological concepts of race started to be seriously questioned by some social scientists "as a package of irrational beliefs" (Barker, 1981, p.1). They maintained that there are no clear genetic boundaries between populations, the distinct racial traits have no value for predicting other biological

aspects and there is little genetic variation between racially defined groups (Gravlee, 2009; Lock, 1993). In this new understanding, race became regarded as a cultural and political concept, a concept which varies across societies and changes with time (LaVeist, 1994). In Backhouse's (2001) words: "People objectified as racially different in one place and time may find themselves shuffled and recategorized or rendered racially invisible in others" (p.10).

LaVeist (1994) illustrated this point with the example of policies that guide assigning racial status in three different countries: USA, Japan and Brazil. For instance, in the USA, a child was assigned the white race only if both parents were white. Children from mixed parents were assigned their race according to the race of their father, with the exception of children of white fathers and non-white mothers who were assigned the non-white race. In this way the presumed purity of the white race was preserved. This policy changed in 1989 so that the mother's race determined the race of children regardless of the race claimed by the father. In Japan, children of a Japanese mother were not considered Japanese unless the father was Japanese. The policy was changed in 1985 so that children of Japanese mothers were considered Japanese regardless of the race of their father. In Brazil, children of interracial mating are referred to as mulattos, the category which is then divided into several subcategories according to the person's skin complexion. Since the policies assigning racial status in these three countries have been, in fact, changed five times in the span of ten years, LaVeist (1994, p.3) correctly questioned the biological relevance of race and concluded that "[r]ace is a concept that is

determined fundamentally by political and social forces without regard to biogenetics or scientific rigor."

Although many scientists agree that race has no biological basis, the practice of applying racial categories to people (known as racialization) continues. Racial status (which is assigned to people by other observers or self-assigned) remains "an important risk marker for exposure to racism which is probably the main etiological factor in producing race differences in morbidity and mortality" (LaVeist, 2000, p.217). Moreover, the contemporary understanding of race is not limited to one's skin colour and visible physical features, but includes categories such as nationality, ethnicity and culture in terms of one's religion, language, dress and customs (das Gupta et al., 2007). It is precisely this new manifestation of racism to which Malcolm X aptly referred as a new model of Cadillac available to people every year. It is people's foreign origin, culture, values and lifeways which became new tools in the process of feeding the rhetoric of racial othering and ordering (Johnstone & Kanitsaki, 2009) and fostering "an increasing global intolerance of accepting immigrants, refugees and asylum seekers" in the West (Clyne, 2005, p.175).

The negative categorization of non-white immigrants continues to be widely reflected in a variety of public discourses that "state or imply the belief in the moral, political, cultural, or technological superiority of white, western 'civilization' when compared to those of (mostly non-white) Third World peoples, including those groups that migrated to the north-western countries" (van Dijk, 1991, p.26). For instance, the ideology of western cultural superiority which underpins the education system can be

illustrated with the statement made by Robert Duchesne, a professor of sociology at the University of New Brunswick. According to him:

> All the traditional disciplines originated in the West, and so did most of the great philosophers, historians, scientists, composers and painters. The very idea of cultural development is Western. Universities have long encouraged the study of non-Western cultures, Chinese philosophy, Islamic Studies, Japanese history, Cultural Studies, and for excellent reasons. The Western disposition to learn from other cultures, to recognize and celebrate the greatness and diversity of others, is itself another reason why we should not think of the West as just one more culture among loads of others. European higher culture must always remain at the center of higher learning because there is no higher culture. Multiculturalism without Eurocentrism is incompatible with a university education. (Duchesne, 2006, n.p., ¶6-7)

This statement also confirms that the racist consequences of Enlightenment ideologies "continue to haunt the modern West: on the non-discursive level, in ghetto streets, and on the discursive level, in methodological assumptions in the disciplines of humanities" (West, 2002, p.48).

Racist ideologies persist, despite the lack of sound scientific evidence to support their validity, partly because they are "rooted in emotionally-charged ethnic stereotypes, highly resistant to change" (Hughes & Kallen, 1974, p.97) and partly because they are deeply embedded in less visible, taken-for-granted, commonsensical institutional beliefs, policies and practices. There are two forms of racism that have implications for non-white immigrants (and other marginalized populations). At the personal level between individual members of society, *personally-mediated racism* can be manifested as lack of respect, suspicion, avoidance, devaluation, scapegoating and dehumanization of the subordinate groups (Jones, 2000). At the societal level, racism is *institutionally-mediated* as both *structural* and *ideological.* Van Dijk (1991) has defined these subtle (yet)

powerful forms of racism as "political, economic, and socio-cultural structures of inequality, and processes and practices of exclusion and marginalization, as well as [their] socio-cognitive representations" (p.27). These *institutionally-mediated* forms of racism are increasingly difficult to recognize since they manifest themselves as "everyday racism … infused into familiar [everyday] practices, … socialized attitudes and behaviour" (Essed, 1991, p.3) which reproduce and reinforce an unrepresentative and exclusionary system for minorities. To put it differently, everyday racism is often invisible in the eyes of many because it is learned as common sense through daily experiences.

Since all of these different forms of racism perpetuate historical injustices, immigrants continue to experience less access to both material and symbolic resources such as rights, employment, housing, education, healthcare, safety, welfare, legal defence, information, respect, social status, and a clean environment (Gallagher, 2004; Jones, 2000). This unfair distribution of resources and power is embedded in a specific social and institutional context that often helps determine these distributive patterns (Young, 1990). For this reason, Young (1990) suggests that our focus should shift from comparing people's possessions to examining "what people are doing, according to what institutionalized rules, how their doings and havings are structured by institutionalized relations that constitute their positions, and how the combined effect of their doings has recursive effects on their lives" (p.25). The institutional context often perpetuates social injustices and discrimination against immigrants and other minorities.

For instance, recent research documented how unquestioned norms and assumptions which underlie institutional rules discriminate against minority groups in higher education. In her example, Clark (2004) argued that children from Gypsy and Traveller families which prefer homeschooling for cultural reasons face discrimination when applying for admission at post-secondary schools. She maintained that this is because the provision of education within a school environment is seen as the norm. In another example of racism in education, Haig-Brown (2007, p.168) documented that the narrative of Canada's "Founding Nations" present in contemporary textbooks tells only the story of British and French colonizers and perpetuates thereby "learned ignorance" about the significance of Aboriginal people in Canada.

Institutional rules and policies also contribute to marginalizing some immigrants and minorities by preventing these people from determining their actions or conditions of their actions and from voicing their needs and experiences. For instance, in Canada, the educational and work opportunities for many immigrant women are restricted and determined by the immigration system because they enter the country as dependents of male migrants and are therefore not eligible for government training benefits (Amin, 2001). In addition, the unfair treatment of their foreign education and work credentials is the reason for exploitation of some immigrants since many are forced to find only unskilled and low-paying jobs (Man, 2004). Galabuzzi (2006) also pointed at non-transparent forms of recruitment practices, such as word of mouth, which tend to reinforce existing networks to which some immigrants rarely have access. In Canada, there is also small but growing number of temporary immigrants such as agricultural

seasonal workers and sex trade workers who work under harsh conditions with minimal pay and legal rights (Omidvar & Richmond, 2003).

However, education and employment are not the only spheres of life in which racialized minorities are exposed to racism. Jones (2000) correctly stated that "the race noted on a health form is the same race noted by a sales clerk, a police officer, or a judge, and this racial classification has a profound daily life experience" (p.1212). In fact, Smedley, Stith and Nelson (2003) suggested in their report on racial and ethnic disparities in healthcare that the racial experience of discrimination is the most intense in healthcare. In Canada, researchers identified that racialized ethnic minorities experience health inequalities in mental health outcomes, diabetes, cardiovascular diseases and HIV/AIDS and also in less access and underutilization of various healthcare services (Enang, Edmonds, Amaratunga & Atwell 2001; Beiser, 2006; Hyman, 2009; McGibbon & Bassett, 2008). To explain these disparities researchers, typically, have used theories of social and economic deprivation, because many racialized minorities live in poverty and experience health risks associated with their socio-economic status. However, the salient role of racism in producing these health inequalities has been increasingly recognized (Hyman, 2009). It is thought that racism influences health directly as prolonged negative stressor affecting the immune system or health behaviours such as substance abuse, self-harm and delaying professional help, and indirectly through other health determinants, namely economic and social deprivation, hazardous working conditions, and inadequate services (Brondolo, Gallo & Myers, 2009; Guruge & Collins, 2008; McGibbon, Etowa & McPherson, 2008; Patrick & Bryan, 2005). For these reasons, Canadian researchers have

proposed that racism should be recognized as an important determinant of health; they call on healthcare professionals and policy makers to address racism as such (Hyman, 2009).

Despite research documenting important links between racism and healthcare some scholars have articulated that many healthcare professionals, policy makers and service providers mistakenly share the notion that racism in healthcare no longer exists (Bosher & Pharris, 2008; Gustafson, 2007; Johnstone & Kanitsaki, 2008). Hassouneh (2006), drawing in part on her personal experience as a faculty member of colour, maintains that the invisibility of racism and Eurocentrism in education of healthcare professionals has reached the extent that the efforts to address the issue "are usually not well received, and faculty of color who raise these issues are often ignored, discounted, and/or pathologized" (p.260).

Similar to racism in other spheres of life, racism in healthcare operates at both the personally- and institutionally-mediated levels. Some researchers have described the experiences of antipathy, avoidance, even disgust and ridicule that racialized minorities have encountered during their interactions with healthcare professionals (Johnstone & Kanitsaki, 2008; Reitmanova & Gustafson, 2008). Jones (2000), however, states that there is no need for any identifiable perpetrator of racist practices because racism has been codified in institutional customs, practices, and laws. In her understanding, "institutionalized racism is often evident as inaction in the face of need" (Jones, 2000, p. 1212). In fact, Canadian researchers identified the following institutional policies and practices disadvantaging immigrants as a racialized population in their pursuit of health:

lack of culturally concordant staff and stakeholders, lack of culturally responsive care and professional training to develop such a care, lack of providing health-relevant information in multilingual and multicultural mode, and indifference to social determinants of health (Guruge & Collins, 2008; Hyman 2009; Reitmanova & Gustafson, 2008; 2009).

Some immigrants and other minorities also experience racism and discrimination in judicial and law enforcement system. For instance, they can become victims of physical violence and abuse (Helly, 2004). The lack of institutional policies and practices dealing with hate crimes might encourage or enable perpetrators to perform more acts of violence. There are reports that the police, too, can become perpetrators of acts of violence or abuse, as was the case of an Iranian-born Muslim RCMP cadet who was harassed and ridiculed for his appearance by his instructors (CBC, 2008). In response to that particular case, the Canadian Human Rights Tribunal ordered the RCMP to adopt mandatory cultural sensitivity training in order to develop and promote a culture of respect and tolerance for diversity. Several other foreign-born Muslim immigrants were discriminated against by laws and policies which allowed the persecution of these persons without the victims knowing what charges had been laid against them (CBC, 2009).

Lastly, popular culture in western societies such as Canada often determines cultural norms and standards to which immigrants should conform (Hughes & Kallen, 1974). Based on the cultural norms, people tend to judge what is beautiful, clever and competent on one side and what is ugly, stupid and inept on the other side while stereotyping, devaluing or degrading some groups (Young, 1990). If immigrants do not

conform to these imagined norms and ideals, they may experience discrimination. An example of this is, for instance, the case of some immigrant Muslim women who were dismissed from schools and work in Canada because they refused to remove the scarf covering their head (Helly, 2004).

The Canadian normative ideal to which immigrants are expected to conform was constructed in the process of nation-building over one century ago. Coleman (2006, p.239), in his work on race relations in Canadian literature, described the following four images which set the course for what a Canadian should look like:

> the loyal brother who continues to negotiate a nervous relationship with the United States, the enterprising Scottish orphan whose prudent, good character produces his economic success, the muscular Christian who meets out justice on behalf of all oppressed people, and the maturing colonial son who demonstrates his independence from Britain and America by altruism towards his minority beneficiaries.

2.3 The Canadian Multiculturalism Act

The above examples of institutional racism in Canada indicate that existing legislation for combating discrimination is ineffective. Henry & Tator (2002) noted that although contemporary western societies such as Canada are committed to democratic principles such as justice, equality, and fairness, they simultaneously foster discrimination against different minority groups. Canada enacted its legislation against discrimination (the *Act for the Preservation and Enhancement of Multiculturalism in Canada*) in 1988 in a response to the 1984 report of the parliamentary Special Committee on Participation of Visible Minorities in Canadian Society. This report indicated that 15%

of Canadians exhibited blatant racist attitudes and another 20-25% had racist tendencies directed against visible minorities. Interviewed research participants regarded visible minorities to be unfit for Canadian public and private institutions due to their differences in culture (Avery, 1995). In addition, the report documented that visible minority immigrants often experienced discrimination in employment (despite their high levels of education and skill attainment) and in their treatment within police and fire departments, government services and universities.

The objective of the *Multiculturalism Act* was not only to promote cultural diversity in Canada but also to promote the full and equitable participation of all persons in all aspects of Canadian society while assisting them in the elimination of any barrier to such participation (Government of Canada, 1985). This legislation intended to ensure that all individuals receive equal treatment and equal protection under the law, while respecting and valuing their diversity. It aimed to assist Canadian institutions to be respectful and inclusive of Canada's multicultural character. Critics of Canadian multiculturalism maintain, however, that the *Act* did not root out racism from Canada because it lacks "a clearly articulated policy of anti-racism, directed at rooting out the effects of racist and white supremacist thinking" (Philip, 1992, p.185). They challenge the form of multiculturalism that celebrates diversity through showcases of immigrant cultures such as traditional cuisine, clothing, art, and language. They see these showcases as a display of the cultures "found in museums or on a bookcase" which "are taken out on a special occasion but afterwards they are put back and everyone returns to normal or British custom" (Crawford, 1998, n.p., ¶31). This form of multiculturalism has limited

potential to address racism. It is important to celebrate diversity through immigrants' delicious cuisine and culture at events such as, for instance, Toronto's Caribana Festival (Thompson and Weinfeld, 1995). However, such celebrations do not eliminate discrimination against some immigrants as illustrated on the case of a Sikh man who had to defend in front of the Supreme Court of Canada his right to wear a turban while serving as a member of the RCMP (CBC, 1990). They also do not eliminate policies that ban Sikh and Jewish veterans from public areas of Legion halls (Sellar, 2006) or eject a Muslim girl from a sports tournament because of their religious headgears (CBC, 2007).

In 2004, the Special Rapporteur on racism, racial discrimination and xenophobia to the United Nations Commission on Human Rights concluded that "Canada has not developed an effective 'intellectual and ethical strategy'… for 'a better understanding of the deep roots of the history, culture and mentality of racism and discrimination'" (Coleman, 2006, p.8). Perhaps these are the reasons for the worrisome findings of a national survey assessing the racial tolerance of 3,092 Canadians. This survey conducted by Leger Marketing in 2007 articulated the following findings:

- Almost 47% of respondents admitted to being at least slightly racist with 21% believing that some races are more gifted than others
- 47 % have a poor opinion about Arabs and 30% have a bad opinion about blacks
- More than 92% have witnessed racist comments or behaviours but only about 33% ever took action to intervene or inform authorities about this behaviour
- 21% have uttered a racial slur and 66% have told jokes with derogatory ethnic meanings

- 57% felt that Canada needs to strengthen its control over the granting of Canadian citizenship
- 52% believed that immigrants should be encouraged to settle outside of major urban centres
- 57% believed that members of all races are treated fairly by the legal system and 48% believed that they are treated fairly by the media. Just 46% believed they are accorded fair treatment by the police

Still another survey conducted with 1,500 Canadians for the Association for Canadian Studies (and published in the *Montreal Gazette*) (Heinrich, 2007) showed the following:

- 20% of respondents thought that minorities should be discouraged from forming their own communities and should abandon their cultural practices
- Approximately 33% liked the idea of a "code of religious and cultural conduct" for immigrants
- 20% objected to the wearing of a head scarf by Muslim women and 25% had a problem with Jewish doctors wearing the kippa scalp-covering on duty
- Just over 33% of respondents did not favour prayer facilities in colleges and universities
- 35% of interviewed Albertans said that society is threatened by an influx of non-Christian immigrants

Avery stated that Canada "still has a long way to go before it can achieve the model society" (1995, p.239) in which all immigrants and minorities are protected by the government and law and are seen as equal to the native born. These 2007 survey findings suggest that Avery's statement published twelve years earlier has not lost its currency. Canada still has a long way to go before it can claim that racism is not an issue within its borders. I agree with van Dijk (1991) that consistent abolition of racism would require "a fundamental transformation of ideological systems which … have been developed during many centuries of political, economic, and cultural western dominance of non-western people" (p.39). Exposing institutional racism, as I did in this chapter, can be one way to affect people's beliefs (their assumptions about what is happening) and their ideologies (their views about how the world should be). Such an exposure can result in movement away from the established system and its principles in order to change and produce another (more inclusive) system.

2.4 Summary

This chapter presented racism as a biological and social concept with roots in the ideologies of biological determinism and social Darwinism developed in the period of European Enlightenment. I showed how these ideologies have led to racism and discrimination against some groups of immigrants in Canada. I focused on the definitions of racism, the forms it takes, and the mechanisms which maintain it. I provided several examples of contemporary institutional racism in education, employment, healthcare and criminal justices systems. Lastly, I critiqued the Canadian Multiculturalism Act for its

inefficiency to address institutionally-mediated racism in Canada. In the following chapter I will focus on TB public health control, especially how it relates to institutional racism, and the discourse of the contagious immigrant in twentieth century Canada.

Chapter 3

TB public health control and racism

> *It is a vicious cycle: Social inequalities shape the biology of racialized groups, and embodied inequalities perpetuate a racialized view of human biology.*
>
> Gravlee, 2009, p.48

The previous chapter described the historic context in which the scientific hierarchy of races was constructed and how this presumed racial ordering fostered the production of racist ideologies leading to racialization and discrimination against certain groups of immigrants. Examples of institutionalized racist practices and policies within the healthcare system, presented in Chapter 2, provide the context for critiquing current immigrant TB control public health policies. These policies are rooted in the historic and ideological context of fears of contagious diseased immigrants that permeated the Canadian society at the beginning of twentieth century. The policies assume a biomedical approach to disease etiology, one which considers immigrants' race or ethnicity (rather than racism) as a health risk. This approach undermines the influence of socio-economic factors such as poverty and the larger context in which socio-economic factors are embedded. This scientific dependence on race as a discrete category which underpins the current immigrant TB control public health policies is an example of commonsensical institutional racism which perpetuates immigrants' health inequalities. The incorrect focus on race perpetuates the uneven distribution of TB in Canada.

In order to debunk the medicalizing and racializing character of TB policies, a brief explanation of the biomedical and epidemiological aspects of TB is needed. The

intent is to enable readers to understand how ineffective the current immigrant TB control policies are and to appreciate my subsequent analysis of the newspaper coverage of immigrant TB in Canada.[4]

3.1 Biomedical and epidemiological aspects of TB

> *...however secure and well-regulated civilized life may become, bacteria, protozoa, viruses, infected fleas, lice, ticks, mosquitoes, and bedbugs will always lurk in the shadows ready to pounce when neglect, poverty, famine, or war lets down the defenses.*
>
> Zinsser, 1934, p.13-14

TB, known also as *phthisis*, *white plague* or *consumption* is an infectious disease caused by tiny bacillus of microscopic size called *Mycobacterium TB*. The TB bacillus can enter a human body in three different ways: through inhalation of droplets, ingestion and skin injection. The most common method of dissemination is the inhalation of droplets dispersed to the air by sneezing or coughing. Although most TB germs die when exposed to dry, hot air or sunlight, one droplet is enough to create an infection. The risk for TB transmission increases with the presence of viable germs in the sputum (a positive smear), the aerosolization of sputum, low air circulation, low sunlight exposure, close proximity to the infectious source, and a weak immune system.

The pathogenesis of TB infection is a complex process that includes several steps. There are several possibilities for interaction between the TB germ and the human body. The primary infection occurs when TB bacilli enter the human body and settle in lung

[4] I will use the 6th edition of Canadian TB Standards (PHAC, 2007) as my primary reference, unless mentioned otherwise.

lobes. In the body with a healthy immune system, the primary infection is immediately recognized and fought against by a cascade of complex immune reactions. If the battle is won, the infected person lives with TB germs dormant in the body (the stage known as latent TB).[5] Of those who effectively fight TB and develop a latent infection, 95% will remain in this stage for the rest of their lives. The remaining 5% of persons with a latent infection will develop a post-primary TB (known as active TB) when TB germs in their bodies awaken from their dormant state. This can happen when the defensive mechanisms of the body fail to protect a person against TB germs. The factors most likely to reactivate TB are stressors to the immune system such as aging, diseases, medications, smoking, alcoholism and substance abuse, institutionalization in asylums and prisons, and also poverty-related issues such as malnutrition, homelessness, overcrowding or devastating living conditions (WHO, 2001).

The most common form of active TB is pulmonary TB which can be manifested with fever, chills, night sweats, appetite loss, weight loss, pallor, and fatigue. The symptoms also include chest pain, a productive, prolonged cough and the coughing up of blood. If TB bacilli are carried by the blood to other locations in the human body, the symptoms are site-specific. Although the extrapulmonary (outside the lungs) TB forms are not infectious to other persons, they are associated with high mortality and disability.

Diagnosing TB is a complex process which depends on the interpretation of several indicators. The major tool used to diagnose TB infection is the tuberculin skin test

[5] In some cases persons may be at risk of developing hypersensitive reactions or primary disease, a mild form of TB (the usual outcome of the primary infection in the body with suppressed immunity).

(TST); results must be interpreted in light of other risk factors in order to avoid misinterpretation. The interpretation criteria are shown in Table 3.1.

Table 3.1: Interpretation of TST (PHAC, 2007)

Tuberculin reaction size (mm)	Conditions for probable TB infection
0-4	Normally insignificant reaction May be significant reaction in people with suppressed immune system, in close contact with TB patients, or in immigrants from endemic countries
5-9	Significant reaction in carriers of HIV infection, in close contact with TB patients, and in people with abnormal chest X-ray
10	Significant in people with all other conditions

Persons with significant positive reactions who are at increased risk of developing TB should undergo preventive drug therapy unless there are contradictions. Another method useful in the TB diagnostic process is the chest X-ray that can reveal specific changes in the lungs. These changes may be accompanied by a variety of clinical symptoms, depending on the stage and localization of the disease. An additional method used in the diagnosis of active TB disease is the collecting of microbiological evidence of TB germs present in a person's sputum, aspirates, urine, spinal fluid or tissue biopsies. The samples may also undergo a variety of biochemical tests, DNA (Deoxyribonucleic acid) testing and testing for drug susceptibility and resistance.

The treatment of TB is a fairly complex issue that involves administering a specific combination of drugs over an extended time period (up to 12 months). The structure of a selected regimen depends on the type and localization of the TB as well as the patient's general health status. The specific drug regimens and their treatment duration are shown in Appendix 2. It is important to note that these powerful drugs have many negative side-effects, such as hepatitis, deafness and kidney failure, which may complicate their use. In addition, a person may develop multiple drug resistance when infected with a resistant strain of bacteria, or due to therapy that is inadequate, inappropriate or irregular. In that case, a second line of more powerful drugs is provided. If a person develops resistance toward any of these second-line drugs, the effect is called extensive drug resistance (XDR).[6] XDR-TB is very dangerous since the treatment options are very limited. WHO (2010) reported that the rates of XDR-TB are increasing worldwide with 58 countries reporting at least one XDR case in 2010. As I will argue, current immigrant TB control may be ineffective in preventing transmission of this non-treatable and lethal (but still very rare) disease in Canada, since it does not address environmental factors in the etiology of immigrant TB.

TB drug therapy can be administrated in outpatient clinics or in patients' homes. The TB patient may be also hospitalized, depending on his/her health status, socio-economic background, and risk of non-adherence. Brudney and Dobkin's (1991) study of

[6] In 1998, a network of Canadian public health agencies and labs established the Canadian TB Laboratory Surveillance Program with responsibility for testing TB germs and reporting on their drug susceptibility (PHAC, 2009a). In 2008, the program identified that 8.8% of all tested isolates (n=1,359) manifested some type of drug resistance. Only 1.1% of the isolates showed multiple-drug resistance. One sample was classified as XDR.

patients with active TB who were not complying with treatment found that 85% were homeless, 83% were unemployed, and 100% of those with cocaine addiction also failed to comply. Therefore service-providers should consider various financial, transportation, family and lifestyle issues that impact on patients' decisions about their health. The issue of non-adherence with TB treatment was studied by WHO (2007a) which developed a strategy called directly observed therapy (DOT) whereby TB workers supervise adherence to the prescribed regimens directly in patients' homes. In the ideal case, once the drug therapy has been initiated, a patient's sputum should be free of germs in 5-6 months. Under these conditions, less than 3% of cases are expected to relapse or acquire resistance and less than 5% will develop adverse reactions to drugs. DOT is therefore considered a very effective TB control strategy but, unfortunately, the heavy emphasis that public health authorities put on this strategy may overshadow the calls for other actions that would address the role of poverty and other social factors associated with TB occurrence (WHO, 2005). The knowledge of the factors associated with the distribution (the frequency and pattern) and determinants (the causes and risk factors) of TB is essential for developing an effective TB control policy and its evaluation.

In the past three decades, TB has become more visible as a global issue. According to WHO (2009), it is the lack of efficient TB-control programs and increasing poverty and social inequalities that make people vulnerable to TB, multiple-drug resistance, HIV-infection and other diseases affecting the immune system. Farmer (1999), an international leader in the area of TB control, and others are critical of characterizing TB as a re-emerging problem. According to Murray (1991) the notion of

TB as a defeated infection is a myth constructed by those in the West who do not feel threatened by the infection and who are unaware or unconcerned about the prevalence of TB experienced in the world's poorer areas. Ott (1996) has made a similar point, saying: "Tuberculosis is not 'resurgent' to those who have been contending with and marginalized by it all their lives. The story ends up as 'Tuberculosis is Back' rather than, more appropriately, 'Tuberculosis is Back in the News'" (p.158).

In 1993, WHO declared the TB situation to be a global health emergency. Despite the efforts of more than 1,000 international health organizations to combat TB under the STOP TB program since that time, the latest WHO (2007a) data indicate that one-third of the world's total population (mostly young adults in their productive years) is infected with TB. In 2007, about 9.3 million new TB cases and about 2 million TB-related deaths occurred (WHO, 2009). Most of the cases were reported in Asia (55%) and Africa (31%), followed by the Eastern Mediterranean Region (6%), the European Region (5%) and the Region of the Americas (3%). The most burdened countries in terms of total numbers of cases were India, China, Indonesia, Nigeria and South Africa. Table 3.2 lists TB prevalence, incidence and mortality rates as reported in all WHO regions in 2007.

The uneven distribution of TB incidence, prevalence and mortality between low and high-income countries is attributed to poverty and material deprivation since the association between poverty and TB is well established (Stop TB Partnership, 2002). According to Hanson (2002), the poor in low-income countries lack income, food, access to water, and sanitation, which increases their risk of exposure to TB infection, the prevalence of active TB and the severity of the disease. Active TB may lead to the loss of

20-30% of an individual's annual income, which further deepens the level of poverty. In addition, the poor in low-income countries lack access to effective TB services due to diverse economic, geographical and socio-cultural barriers (WHO, 2005). They also face health system barriers which include lack of health system responsiveness and the consequences of structural changes such as decentralization. It must be noted here that many low-income countries with the high burden of TB became a very important source of immigrants to Canada in the past two decades (CIC, 2009). There is a high probability that these immigrants were exposed to latent TB before coming to Canada.

Table 3.2: TB rates in WHO regions in 2007 (WHO, 2009)

	Incidence[a]		**Prevalence**[b]		**Mortality**[c]	
WHO region	number 1000s	per 100000	number 1000s	per 100000	number 1000s	per 100000
Africa	2 879	363	3 766	475	735	93
The Americas	295	32	348	38	41	5
Eastern Mediterranean	583	105	772	139	105	18
Europe	432	49	456	51	64	7
South-East Asia	3165	181	4 881	280	537	30
Western Pacific	1 919	108	3 500	197	291	17
Global	**9723**	**139**	**13723**	**206**	**1 772**	**27**

[a]Incidence: the number of new cases arising in a given period
[b]Prevalence: the number of cases existing in the population at a given point in time
[c]Mortality: the number of deaths occurring in a given period

Similar disparities in the distribution of the TB burden exist also within high-income countries. For instance, the available data indicate that incidence, prevalence and mortality rates in both the USA and Canada are the lowest in the world, however, the numbers can be deceiving as they do not reveal great disparities in the distribution of TB among different populations living in the two countries. Farmer (1999) showed that while TB rates among whites in the USA have steadily declined, the rates among blacks have increased by 6.8% and among Hispanics by 12.7%. TB rates of Canadian Aboriginals in some northern parts of Canada are similar to those found in the Eastern Mediterranean (PHAC, 2008b). Similarly, the TB rates in London's Newham district (the most ethnically diverse district with one of the lowest indigenous British populations in the UK) are higher than in India (Gandy & Zumla, 2003). In fact, immigrants often represent the highest proportion of TB cases in their receiving countries. King (2003) provided the following statistical data from diverse western countries on the proportion of cases of immigrant TB from all cases reported in the 1990s: Australia 73%, Sweden 66%, Switzerland 51%, Netherlands 56%, Denmark 38% and Italy 23%. The incidence rate of children's TB in socially disadvantaged immigrant communities reaches up to 50 per 100,000 compared to the rate 1-10 per 100,000 of their non-immigrant counter-parts (WHO, 2007b).

In general, numerous studies have shown that vulnerable and marginalized groups, such as visible minorities, immigrants, indigenous populations, the homeless, those who inject drugs and prisoners carry the highest burden of TB due to pockets of deprivation that exist in high-income countries (WHO, 2005). Many of these groups live

in deprived neighbourhoods where there are limited employment opportunities, a lack of affordable housing, lower levels of nutrition and little or no access to health and social services (Farmer, 1999; Fleury, 2007; Gandy & Zumla 2003; Kazemipur & Halli, 1997; WHO, 2005). Despite the documented social inequalities, TB control policies tend to focus almost exclusively on screening and surveillance of immigrants rather than on addressing the factors that trigger the TB reactivation long after immigrants have been exposed to the infection in their countries of birth (Ho, 2003; King, 2003; Littleton et al., 2008). The following section will explore these issues within the Canadian context.

3.2 Immigrant TB and its public health control in Canada

> *The current system has a number of shortcomings, including lack of notification of the appropriate Canadian public health authorities, poor adherence to the guidelines for medical surveillance in Canada and low rates of preventive therapy among those referred for surveillance. As a result, opportunities to prevent future cases of TB may be lost.*
>
> Wobeser et al., 2000, p.827

In Canada, 66% of the reported 1,547 new active and relapsed cases in 2007 were among the foreign-born population (PHAC, 2008b). The Aboriginal population accounted for 20% and the non-Aboriginal Canadian-born population for 11%. The PHAC (2008a) data indicate that the immigrant population accounts for the highest proportion of TB in Canada since late 1980s, and between 1980 and 2007 the proportion of immigrant TB in Canada has increased from 35% to 66%. This trend in distribution of TB cases among three different populations in Canada is captured in Figure 3.1. In 2007,

Ontario, British Columbia, Quebec, and Alberta continued to carry the highest burden of immigrant TB in the country (PHAC, 2008b).

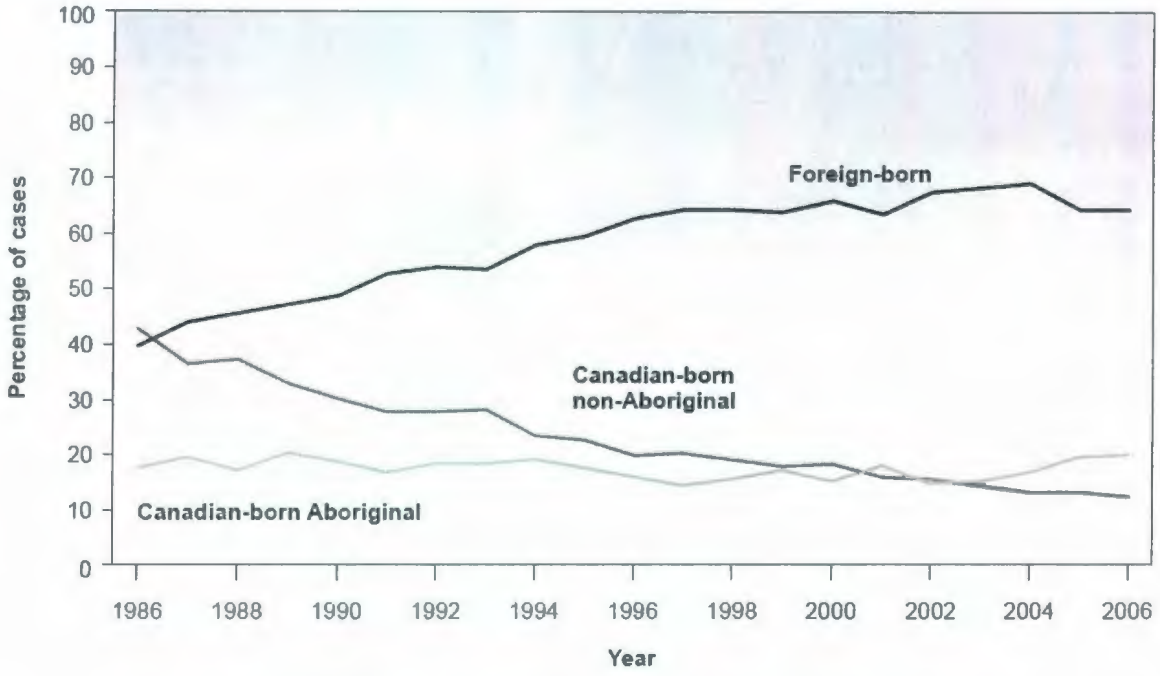

Figure 3.1: Percentage of cases by origin between 1986-2006 (PHAC, 2008a, p.11)

The risk of disease reactivation persists for many years after arrival (PHAC, 2007). Hyman (2001) noted in her review of research on immigrant TB in Canada that the majority of immigrants developed TB due to post-migratory reactivation of a previous infection rather than due to acquiring new infection in Canada. Several studies found that the mean latency period between immigration and diagnosis ranged from 9 years in Ontario (Kerbel, 1997) to about 14 years in Alberta (Cowie and Sharpe, 1998). A shorter latency period was found among refugees from Somalia, Ethiopia, Sri Lanka and

Afghanistan who developed TB between two to four years after their arrival in Canada (Public Health Research and Evaluation Division, 2000). More recently, PHAC (2007) reported that 41% of TB reactivation cases appear five years after the arrival of immigrants with latent TB in Canada.

The risk of transmission of TB to the Canadian-born population is, however, very limited (Hyman, 2001). For instance, a cross-sectional Montreal study showed that TST reactions of non-vaccinated Canadian-born children were not associated with any indices of contact in school, work or neighborhood settings with foreign-born from TB endemic areas (Menzies et al., 1997). By contrast, the risk of transmission inside immigrant communities was greater since many immigrants had little protection from TB due to their living conditions (Carballo, Divino & Zeric, 1998). In fact, several other studies show that poor living conditions, homelessness, overcrowded housing, malnutrition, lack of sanitation, substance abuse, and limited access to services accounted for TB reactivation in immigrants (Kent, Crowe, Yung, Lucas, & Mijch, 1993; King, 2003; McSherry & Connor, 1993; Menzies et al., 1997). There also appears to be a link between TB reactivation and resettlement stress that compromises immigrants' immune systems (Davies, 1995).

The control of TB within the immigrant population includes the following directives (PHAC, 2007): Foreign-born persons with active TB are not allowed to immigrate to Canada until they complete a satisfactory treatment regimen and the

medical examiner confirms a positive reassessment of their condition.[7] By contrast, persons diagnosed with latent TB and those who have recovered from TB are conditionally granted an immigration visa. These immigrants are required to report to the provincial/territorial public health authorities within first 30 days of their arrival. Immigration port of entry officials provide contact information to immigrants. Immigrants who provide evidence of compliance with the medical surveillance to the local immigration office will then have these conditions removed from their visa.

After the initial contact with the public health authorities, immigrants are subject to further screening and surveillance. The purpose of screening activities (such as chest X-ray, sputum smear and TST) is to "discover conditions suitable for early preventative or curative intervention" in order that immigrants with TB can access "prompt and definite medical attention" (Health Canada, 2000, p.187-188). Surveillance is defined as as

> the ongoing process of a) systematic collection of pertinent data, b) the orderly consolidation and evaluation of these data, and c) prompt dissemination of the results to those who need to know [or act in order] to reduce the emergence of disease and the spread of infection through early case detection and treatment, and identification and treatment of [high-risk] persons with latent infection (Health Canada, 2000, p.187).

Immigrants who have been diagnosed with either latent or active TB through screening and surveillance are then administered by their healthcare providers the appropriate drug

[7] For humanitarian reasons, these rules do not apply to refugees whose poor health condition (if present) might otherwise prevent them from being granted asylum in Canada. Refugees are required to be properly examined within 60 days (5 days in Quebec) of their arrival.

regimen. Follow-up screening and surveillance is discontinued three to five years after the completion of treatment (see Figure 3.2).

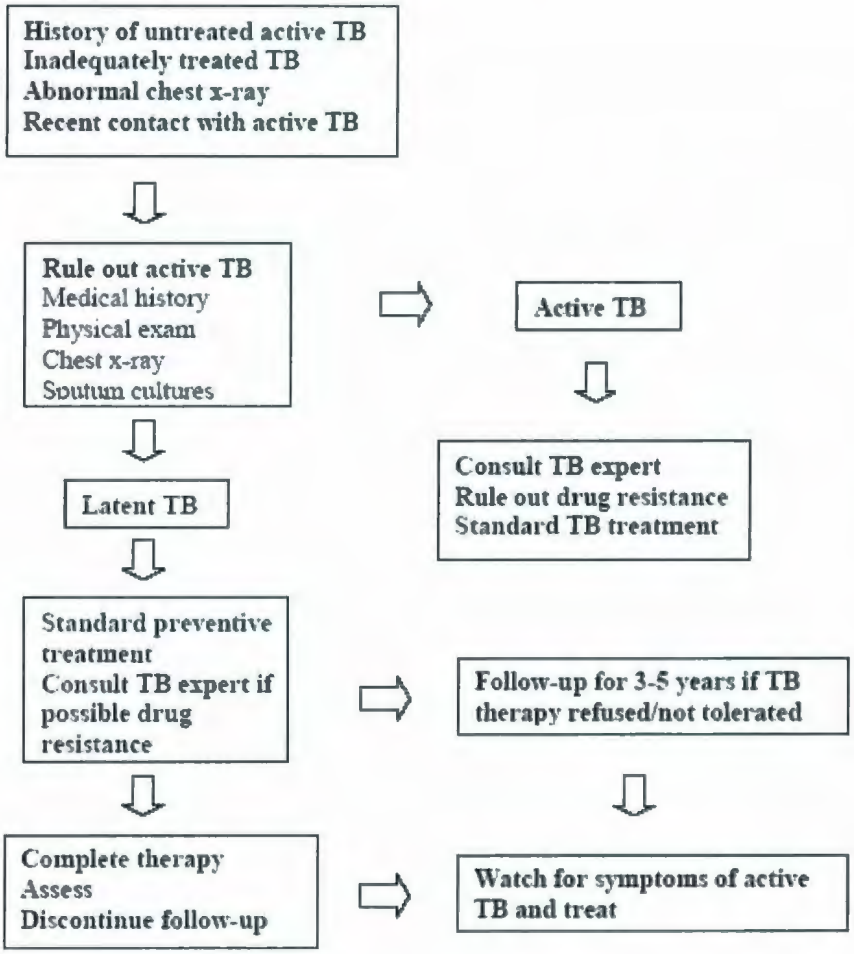

Figure 3.2: Follow-up of new immigrants for TB (Health Canada, 2000, p.231)

Screening and surveillance of immigrants with TB is organized through two models of TB control available in Canada: the centralized model, and the combined centralized and decentralized model (Health Canada, 2000). The centralized model of clinical services was developed from the sanatorium services used in British Columbia,

the Prairies and the Canadian territories. The combined model of services, including the services of community-based specialists and primary care physicians, is in place in Ontario and Atlantic Canada. The local health services providers are required to report any newly diagnosed or reactivated TB cases to the local public health authorities. The information about demographic data, risk factors, sites and stages of the disease, results of diagnostic and laboratory tests as well as therapeutic procedures and outcomes is passed from the provincial authorities to the national database managed by the TB Prevention and Control Division of PHAC.[8] The TB rates and trends are then annually reported by PHAC and compared among different jurisdictions in Canada and internationally.

According to PHAC (2007), the proportion of immigrant TB cases grew 3.7-times since 1970s. Some may suggest that this growth is caused by an increased number of immigrants who come to Canada from the countries with a high TB burden. Because immigrants are not routinely screened for latent TB before or after coming to Canada, few may be aware that they carry the bacteria. This means that immigrants with latent TB may not be subject to surveillance in Canada and therefore at increased risk of the TB reactivation. However, screening all immigrants for the latent TB is considered impractical since only 5% of those with latent TB develop the active disease and there is no evidence that immigrants with latent TB endanger other Canadians when they develop active TB (Fanning, 1995; Hyman, 2001; Menzies et al., 1997; PHAC, 2008a). In addition, it would be very expensive to screen the 250,000 immigrants admitted annually

[8] The report form is available in Appendix 3.

to Canada and provide prophylactic treatment for those diagnosed with the latent TB (Fanning, 1995). Moreover, the treatment is known to have severe side effects that may pose an unnecessary health risk to some immigrants.

The second factor which may impact on the increasing TB rates of immigrants is the policy that discontinues the follow-up of immigrants with diagnosed latent TB three to five years upon the completion of their prophylactic drug treatment. Whether the treatment is effective in preventing the reactivation of TB in the immigrant population in Canada is not known as no such data are available. However, the available data indicate that 41% of TB reactivation cases appear five years after the immigrants' arrival and the risk of disease reactivation persists for many years after arrival (PHAC, 2007). This means that even if the surveillance of immigrants is available it does not last long enough to capture a large number of the reactivated cases.

Third, some research indicates that poverty-related factors, such as homelessness, overcrowded housing, malnutrition, lack of sanitation, substance abuse, and limited access to services, account for TB reactivation in immigrants (Kent et al., 1993; King, 2003; McSherry & Connor, 1993; Menzies et al., 1997; WHO, 2005). However, the current TB policies outlined in the latest edition of the *Canadian TB Standards* (PHAC, 2007) do not address poverty as a determinant of TB reactivation among immigrants. Interestingly, however, PHAC acknowledges that poverty creates an environment that promotes TB among the Aboriginal peoples of Canada and should be taken into consideration when planning effective TB control in this population. This may be due to the fact that policy makers are better informed about the poverty and TB on reserves

(Clark, Riben & Nowgesic, 2002) since TB issues of Aboriginal people in Canada are better researched than those of immigrants and the Aboriginals have better representation when it comes to formal advocacy and lobbying their issues (Rock, 2003). PHAC has not yet extended the same understanding to tackle TB in the immigrant population by addressing socio-economic factors.

Poverty-related factors are regarded as well-known risk factors associated with TB (WHO, 2005). A closer look at immigrants' post-migration experience in Canada can demonstrate that social issues can, in fact, explain the uneven distribution of TB between the immigrant and non-immigrant population better than the notion of disease importation or insufficient screening and surveillance. In 2003, almost 30% of recent immigrant families and 42% of unattached immigrants who came to Canada after 1990 lived in poverty (National Council on Welfare Reports, 2006). The poverty rates among all immigrant families were twice as high as those in Canadian-born families. As for the immigrants who came to Canada in the 1980s, their poverty rates were still high in 2003 with almost 20% of the families and 57% of the unattached immigrants living in poverty.

According to Fleury (2007), in 2004 more than one in five recent immigrants of working age were living in poverty (compared to fewer than one in ten Canadians). Immigrants were over-represented among all groups of poor people in Canada. However, recent immigrants living in poverty were less dependent on social assistance than were other poor Canadians. In addition, three out of five recent immigrants not living in poverty were more likely to fall into poverty in the future. The Census 2006 survey found that the median earnings of a Canadian-born person with a university education were

$51,656, twice as high as those of a recent immigrant with the same education level ($24,636) (Statistics Canada, 2008).

TB is considered an urban disease in Canada. The poverty rates among immigrants residing in large metropolitan areas such as Calgary, Ontario's Durham Region, Edmonton, Hamilton, Montreal, Ottawa, Toronto, Vancouver and Winnipeg varied between 50-70% for permanent immigrants and 60-80% for refugees (Lee, 2000.) Not surprisingly, in 2004, 66% of all active TB cases in Canada were reported from these areas (PHAC, 2007). For instance, in 2000, 20% of people residing in poor inner-city neighbourhoods of Toronto were immigrants (more than double the rate in the general urban population) and there was an increasing refugee and immigrant homeless population in the city with families constituting the highest proportion (Hay et al., 2006). The homeless in Toronto were found at increased risk of developing TB (Khandor & Mason, 2007). Residing in the disadvantaged neighbourhoods, many immigrants also experienced high unemployment and underemployment, low-income, fewer educational opportunities, social dysfunction, overcrowded housing, malnutrition, substance abuse and lack of access to services (Hay et al., 2006). Not so surprisingly, 82% of reported TB cases in Toronto were represented by the foreign-born population (PHAC, 2007). Another study indicated that immigrants accounted for 77.3% of all active TB cases in Montreal between 1992 and 1995 (Rivest, Tannenbaum & Bedard, 1998). The majority of these immigrants lived in poverty.

The racialization of poverty may also account for the high rates of TB among immigrants in Canada. The highest poverty rates in Canada are found among visible

minorities such as African, Arab, Asian, Caribbean, Central and South American ethnic groups (Ornstein, 2006). Not unexpectedly, the highest TB case load in 2007 was reported among immigrants from the Western Pacific, followed by immigrants from South-East Asia, Africa, the Eastern Mediterranean, Latin America and the Caribbean, Central and Eastern Europe (PHAC, 2009b), as shown in Figure 3.3.

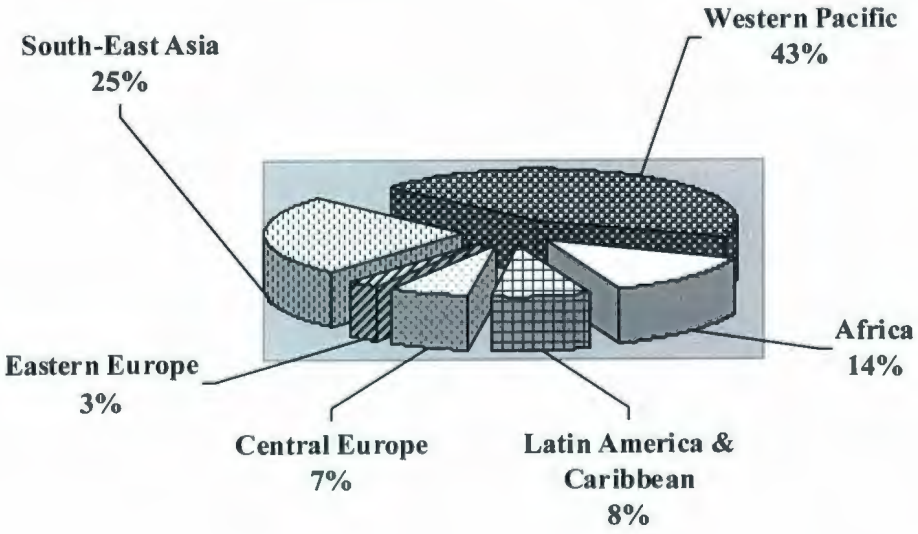

Figure 3.3: TB case distribution by immigrants' origin in 2007 (PHAC, 2009b)

The statistics also show that in 2005 almost 22% of all Aboriginal people in Canada were living in poverty (Statistics Canada, 2006). Not surprisingly, members of this population also faced high risk of developing TB (CPHI, 2004).

Another known health determinant that interplays with the risk of developing active TB disease among immigrants is that of gender. Health inequalities are often "linked to disparate access to resources determined by cultural attitudes toward gender, class, social policy and labour market patterns" (Spitzer, 2005b, p.80). In the past the burden of TB was higher within the male population in Canada. In 2007 this trend persisted with 846 cases (55%) reported among men and 702 cases (45%) reported among women; however, there was a gradual decrease in the differential between males and females when compared to the past statistics (PHAC, 2009b). The greatest burden of active TB within the entire female population in Canada was carried by immigrant women who accounted for 71% (n=500/702) of all female cases. Aboriginal women represented 18% (n=127) of cases while non-Aboriginal Canadian-born women represented only 8% (n=59). In addition, in the immigrant population women represented 48% (n=500/1,042) of all TB cases. In the Aboriginal population women represented 41% (n=127/307) of all TB cases while in the non-Aboriginal Canadian-born women represented only 35% (n=59/170) of all TB cases. This means that TB was unequally distributed among female populations in Canada with immigrant women representing the highest burden of TB.

While the male population in general accounted for the majority of active TB cases, this was not true for the category of immigrant women in the age category 15-34 where women represented 53% (n=163/305) of cases. Also, in the population of South East Asian immigrants women represented 54% (n=125/233) of cases. This means that some groups of immigrant women have higher rates of TB than their Canadian-born

counterparts and also higher rates than immigrant men. It is possible that these populations of women bear an unfair TB burden because their access to sustainable income, social support, quality housing and non-discriminatory, safe and clean environment is, to varying degrees, often limited (Spitzer, 2005b).

To my knowledge, no studies have examined the multiple and complex intersectionalities of gender, ethnicity, class and other social determinants as a way to explain the inequitable burden of TB among some Canadian populations. In the absence of specific studies and in light of our current knowledge of the impact of social inequalities on health, it is not unreasonable to assume that social inequalities shape the risk of TB reactivation in racialized groups such as immigrants. The embodied inequalities such as a higher TB burden in these populations then perpetuate our racialized view of their biology. It is, indeed, a vicious cycle as Gravlee (2009) expressed in the quote opening this chapter. Statistical evidence exists that a) poverty is highly associated with the risk of TB exposure and re-activation in the immigrant and Aboriginal populations, and b) a large pool of Canadian immigrants live in poverty and may have latent TB. However, Canadian TB control is not currently informed by this evidence to the disadvantage of the health needs of the immigrant population. Public health policies attribute the highest concentration of TB within the foreign-born population in Canada mostly to their country of birth and to factors such as insufficient referral for medical surveillance, barriers to primary healthcare (economic, cultural and linguistic), advanced age, lower education level and immigration category (refugee), as well as being single or widowed (Wobeser et al., 2000). The problems surrounding the

high (and continuously increasing) burden of their poverty are not explicitly stated. For these reasons, current TB control strategies in the immigrant population rely primarily on screening and surveillance.

The narrow focus on screening and surveillance does not reflect the well-known triad model for infectious disease. According to this model, there are three basic factors (an agent, a host, and an environment); the complex mutual interaction of these three can result in disease (CDC, 2006). In order to develop effective public health measures to prevent and control disease all three components and their interaction must be assessed. In the triad model, the agent (pathogen) is transmitted from a source to a susceptible host in a supportive environment. There are many intrinsic factors, such as age, sex, health practices, biological and psychological make-up, and health status, associated with the host that influence his or her susceptibility to infections. The environment refers to a set of external factors which affect the opportunity for exposure. Besides physical factors (e.g. climate) and biological factors (e.g. insect vectors), these factors also include important socio-economic factors such as crowding, nutrition, sanitation, and availability of services (CDC, 2006). However, the current immigrant TB public health policies in Canada lack such an assessment of environmental factors, since they rely on the biomedical model of health and disease. The biomedical model reduces health to the physical observation, categorization and explanation of the patients' bodies and assumes that the reasons for ill health lie in pathological, biological, and chemical processes inside and outside the human body (Clarke, 2004). Because the impact of social, psychological, spiritual and economic factors on health is de-emphasized, the biomedical model offers

biological explanations and solutions for social problems. The following section traces the historic and ideological roots of current TB control policies in order to understand their racializing and medicalizing character.

3.3 Fingerprints of colonialism on immigrant TB control public health policies in Canada

> *Focusing too closely on the role of individual carriers of the tubercle bacillus diverts attention from the more complicated socioeconomic and structural problems that contribute to the spread of TB. It is, for example, much simpler to identify Russians as potential carriers and screen them upon entry into the USA, than it is to interrogate the role of the recent 'shock therapy' – driven transition to a market economy in the explosion of TB in that country.*
>
> King, 2003, p.49

The process of policy development is grounded in a complex political, social, economic and historic context. The factors which influence if and how an issue becomes a focus for public policy interventions (policy formulation) and how the policy goals are transformed into results (policy implementation) are complex processes. Because "issues and policy problems are constructed out of the conflicting values and terminologies that different groups put forward" (Brooks & Miljan, 2003, p.), the process is further shaped by existing political structures, institutions and institutional actors (Lavis, 2002). In order to understand the context in which current TB control policies were developed, this section traces the historic and ideological roots of the fear of the contagious diseased immigrant evident in Canadian society at the beginning of twentieth century (Avery, 1979; McCuaig, 1999; McLaren, 1990; Valverde, 2008). The historic account of Canada's dealings with TB clearly demonstrates how a disease can become a political

construct in which race, nationality, ethnicity and social status shape the biomedical understanding of disease and consequently impact the development of effective policies. Current TB control policies emerged out of the values and terminologies that were put forward by notable Canadian public health reformers, prominent physicians, and social workers at the end of nineteenth century (McCuaig, 1999; McLaren, 1990). Their values and terminologies were heavily influenced by the ideology of racial hierarchy and by subsequent fears of presumed immigrants' vices (such as TB) which posed imminent social and moral degeneration of the Anglo-Saxon race (Devereux, 2005; McLaren, 1990).

The ideology of racial ordering in the public health sphere in Canada can be traced to two historic events: First was the globalization of diseases between the New World and the Old World propelled by the European conquest of the Americas and the transatlantic slave trade (Aginam, 2003). Disease pathogens criss-crossing geo-political boundaries triggered international efforts to manage infectious diseases on a wider global scale. The second event was the development of pseudoscientific categories of race, Darwin's evolution theory and Mendelian inheritance laws during the Enlightenment era (as described in Chapter 1). These belief systems constructed a racialized hierarchy where non-white races were deemed inherently uncivilized, dirty, and diseased (Lupton, 1999) and reinforced the existing sick-immigrant paradigm. According to this paradigm, which originated during European travels to North America in the sixteenth century, it was assumed that diseases are often the reason which forces immigrants to leave their

homelands (Beiser, 2005). The notion that immigrants bring disease with them then motivated many anti-immigrant public policies.

It was the two outbreaks of cholera affecting both Europe and North America in the middle of the nineteenth century which demonstrated that protecting both continents against diseases was beyond the capacity of individual states and the solution required a multilateral response to the epidemics (Aginam, 2003). The need for consistent and efficient quarantine regulations was also accentuated by the new imperative of growing international trade and travel after the openings of Suez and Panama canals. Subsequently, several European states organized and participated in sanitary conventions on the cross-border spread and surveillance of infections such as cholera, plague, and yellow fever beginning in 1851. Governments introduced new measures such as the systematic use of health certifications for immigrants, who were required to document they were free from infectious diseases and vaccinated (de Waal, 2008).

American-based philanthropies such as the Rockefeller Foundation's International Health Board supported the British administration in their control of infectious diseases and made similar efforts to combat the threat of yellow fever in Cuba and Panama (Bashford, 2006). Canada joined these collective efforts in 1869 by introducing its first *Immigration Act* (Canada in the Making, n.d.) which dealt with preventing various infectious threats from entering Canada. In 1872, quarantine rules regarding sick or deceased passengers were introduced. All vessels transporting the sick were required to report at Grosse Ile in Quebec which served as a quarantine point.

Quarantine, however, was not the only public health measure to deal with those immigrants who were considered diseased. The fear of immigrants often led to "campaigns against immigrant-run street markets and fruit stalls, which were condemned as germ-ridden threats to the public health" (Tomes, 2000, p.195) and to riots in which many immigrant businesses were destroyed (McLaren, 1990). On the west coast of Canada, Chinese immigrants were feared because they were believed to carry venereal diseases and infections such as smallpox and leprosy since "within the colonial imagination, China was marked as a diseased place, a country plagued by illness and contagion" (Mawani, 2003, p.8). As a result of the racialized association between leprosy and the Chinese identity (which was, according to Mawani (2003), not supported by any reliable medical data), leprosy became known as a "Chinese disease." The fears of this disease consequently led to the creation of Canada's first and only leper colony at D'Arcy Island in British Columbia in 1891 (Mawani, 2003).

However, the fate of persons with TB coming to Canada was initially different from those with other infectious diseases such as leprosy. A newer version of the Immigration Act was introduced in 1906 that prevented people with TB from entering Canada or deported them if they were diagnosed with TB (McLaren, 1990). Prior to that time, Canada had been characterized as a healthy place to live or recover from TB, serving as a reason to attract immigrants to the newest British colony (Devereux, 2005; Hupfer, 1998). For instance, in the recruiting document issued by the Canadian Pacific Railway in 1886, testimonials from dozens of Canadian women claimed that their TB had improved in Canada after a short time, due to the "exceedingly healthy climate"

(Canadian Pacific Railway, 1886). These lay accounts were officially supported by renowned medical scientists of the time. For instance, Dr. William Hales Hingston of Montreal asserted that Canadian "dry air and cold winter… [were] decided recuperators of such diseases as consumption" (Devereux, 2005, p.79). A British physician, Caleb Williams Saleeby, maintained that "the cold and sun of Canada, playing upon the well-fed, produce a splendour of physique, a low rate of disease [TB], an abundant energy of mind, a joie de vivre, or national euphoria" (Devereux, 2005, p.80).

However, the situation changed dramatically at the beginning of the twentieth century when the rates of TB-related deaths and disabilities in Canada became alarmingly high. According to Connor (1990), TB caused the death of one Canadian every hour of the day and every half hour of the night. TB became increasingly associated with immigrants and regarded as an imported disease despite the statistical evidence that, for instance, Quebec's factory workers returning home from the United States had higher TB rates than immigrants (McCuaig, 1999). In the words of one Toronto physician:

> ...they [immigrants] have been advised to come to this country on account of the bracing climate being so beneficial to persons suffering from pulmonary tuberculosis...The evidence would seem to show this country is simply the dumping ground for those afflicted with tuberculosis and other diseases (cited in McCuaig, 1999, p16).

Fears about the magnitude of the disease were accentuated by the problems with labour unrest and overcrowding in unventilated urban slums with poor sanitation, since the population in Canada grew by 64% in the twenty years after 1900 (McCuaig, 1999). For instance, a governmental report published in 1908 described the situation in Toronto as follows:

> In our city at the present time there is scarcely a vacant house fit to live in that is not inhabited, and in many cases by numerous families; respectable people have had to live in stables, tents, old cars, sheds (others in damp cellars), where we would not place a valued animal, let alone a human being (cited in Wherrett, 1977, p.11).

In this new socio-political climate, TB had become a problem which needed to be eliminated along with the immigrants who carried it. Physicians who once boasted about Canada's healthy skies to attract infected British immigrants, constructed a powerful new image of TB. At the beginning of twentieth century TB was increasingly seen as a "racial poison" which, like the use of alcohol and venereal diseases, was believed to decimate the quality of the Anglo-Saxon race and bring a moral decay to the society (Devereux, 2005; McLaren, 1990). These new beliefs about TB were also conflated with the prevalent eugenic beliefs of biological determinism, according to which the genes of all non-white immigrants and poor white immigrants were inferior and therefore these groups of people were more predisposed to diseases than the superior non-poor white class (Devereux, 2005; McLaren, 1990). To prevent the hereditary degeneration of the British race, the carriers of these supposedly inferior genes were the focus of a eugenics agenda that intended to improve overall racial qualities of the population. The goal to keep the nation strong and healthy lay presumably in controlled reproduction, social reformation and controlled immigration which would eliminate all defective, inassimilable, and unfit people from the Canada's white Anglo-Saxon and Protestant "breeding stock" (Chapman, 1977; Devereux, 2005; McLaren, 1990, Valverde, 2008).

Eugenicists in some parts of Canada believed that people with TB would bring "poor, feeble, miserable members into the world who would have no strength and

vitality" and would fall easy victims to this disease (McCuaig, 1999, p.15). TB became one of many reasons why eugenicists opposed the marriage of people with TB and lobbied for birth control in this population. In 1928, their efforts resulted in the proclamation of the *Sexual Sterilization Act* of Alberta (and later of BC) that justified the sterilization of many 'feeble-minded' women including immigrant women in order "to promote the mental and physical betterment of the race" (McLaren, 1990, p.101). The term feeble-minded was often used to describe poor single mothers. This population was more likely to have TB since poverty-related conditions in which many of these women lived are strongly associated with TB risk. The forced sterilization became a sad example of institutional oppression and discrimination of many minorities including immigrants until the Act was repealed in 1972 (Devereux, 2005).

TB was one of the collective ills of Canadian society which were also targeted by Social Gospel movement which drew its strength from Protestant faith and values (McLaren, 1990; Valverde, 2008). The purpose of this movement was to encourage healthy sexuality and moral purity of the new nation in order to resolve problems such as prostitution, illegitimacy, divorce or mixed marriages. Movement members regarded immigrants of non-white races as "savages" who could not control their sexual desires and thus could not lead a civilized life unless they learned Protestant habits of life and adopted British culture (Valverde, 2008). Like eugenicists, movement followers believed in the biological determinism of racial ordering; however, they also believed in the power of spiritual, moral and social reformation. For this reason, they engaged in extensive missionary work to Canadianize and Christianize immigrants through education and

material support. Their purity work also included lobbying the government to bring in "purer" immigrants and deport those deemed unfit.

Reformers' calls for controlled immigration were also endorsed by many prominent physicians who employed eugenic arguments in the immigration debate (McLaren, 1990). It was understood that in order to build a healthy and pure nation, it was necessary to avoid bringing in those who were unhealthy. This sentiment resonated in the question raised by Dr. John George Adami, former president of the *Canadian Association for the Prevention of TB* and a Canadian delegate to the International Congress of Eugenics in 1912:

> Is it not better for us in Canada to increase our population by saving our own and making them strong and healthy rather than by spending our national money in bringing in Doukhobors, Galacians, Poles and the depressed peoples of Southern and Eastern Europe? (Adami, 1909, p.151)

In 1906, those known to have TB or other infections such as syphilis and leprosy were barred from entering Canada (McLaren, 1990). The categories of immigrants regarded not eligible to immigrate to the country expanded to include "idiots, imbeciles, feeble-minded persons, epileptics, alcoholics, criminals, and anarchists" as well as persons who were "insane, dumb, blind, physically defective, and illiterate" (Government of Canada, 1924). The medical assessments of immigrants took place in Quebec, Halifax, Saint John, Montreal, and Winnipeg (McLaren, 1990) where "groups often of 1,000 and over, and as many as 7,000 have arrived in a single day" (Woodsworth, 1972, p.192). Unfortunately, records do not show how immigrant assessments were done and to what degree they were objective.

The calls for the improvement of the federal immigration policy made by Dr. Adami, among others, resulted in establishing legal mechanisms for deporting those who were considered ill or unfit (Mawani, 2003). Government documents show the following health reasons for deporting immigrants trying to enter Canada: rheumatism, failing eyesight, physical and mental weakness, heart disease, varicose veins, leg ulcer, empyema, deafness, twisted neck and head, old age, lost eye and thumb, pregnancy, immorality, vicious tendencies, chronic dysentery, diabetes, Bright's disease, skin ulcers and abscesses, malformations, frost bites, lead poisoning, and bad character (Woodsworth, 1972). This list shows that the reason for deportation was often not sound morally or medically justified since many of the listed health conditions do not exclude people from full and meaningful contribution to society.

Although the system of deportation turned into "an important technology of nation building, allowing political officials to banish and exile those who were socially, morally, and physically unfit" (Mawani, 2003, p.13), eugenicists were not satisfied with the system of medical screening and deportation upon the arrival of immigrants to Canada. They pushed for a thorough medical examination taking place in the immigrant's country of origin (McLaren, 1990). Eventually, the routine chest X-ray examination for TB abroad was introduced in England in 1948 when Dr. George Clair Brink, the director of Ontario's Division of TB Control, inaugurated this program by bringing with him a Canadian X-ray machine (Saskatchewan Lung Association, n.d.). Around the same time, Canadian physicians called for repeated X-rays of immigrants already in the country for a

period of two to three years after their admission date (Adamson & Edmison, 1947). This surveillance routine is still in place today (PHAC, 2007).

The advent of antibiotics in the late 1940s was another turning point in Canada's struggle with TB (Feldberg, 1995; McCuaig, 1999). Free drug therapy was significant because it was effective in curing active TB. However this advance simultaneously diverted attention away from the important role of preventative public health measures such as improvements in personal hygiene, nutrition, housing, garbage disposal and sewage systems, pasteurization of milk, screening and isolation of the sick in sanatoria, vaccination, and social assistance to disadvantaged patients. The heavy focus on antibiotics changed the perception of TB as a social disease with a medical aspect, to a medical disease with a social aspect (McCuaig, 1999). Today, the role of social factors in the preventative public health measures continues to be de-emphasized. Current immigrant TB control policies rely on screening, surveillance and drug therapy.

3.4 Summary

In this chapter I explored the historic roots of current immigrant TB control policies in order to reveal their racialized and racist foundation. The nineteenth century construction of a racial hierarchy, supported by eugenic beliefs about the biological, moral, intellectual and economic superiority of the white race, shaped the policies which attributed the TB problem to immigrants' presumably inferior genes. The advent of drugs to treat active TB in 1940s also shaped the biomedical focus of current TB policies which offered biological explanations and solutions for the TB problem. These policies have not

been changed for a century. All prospective immigrants are subject to medical assessment. Those with active TB are barred from entering the country. Those with latent TB are preventively treated and monitored. Current policies contribute to the racializing TB and its carriers because they reinforce the misconception that the uneven distribution of TB in Canada is related to immigrants' foreign origin (i.e. their race, ethnicity, or nationality). Policies continue to overlook the link between TB and the post-migration experience of poverty.

TB control policies are also racist policies because their unresponsiveness to immigrants' social needs increases the TB burden within the immigrant population. Some say that this is because of the limited political power and resources available to immigrants to confront systemic discrimination and institutionalized racism (Gandy & Zumla, 2003; Reitmanova & Gustafson 2008; Young, 1990). Others point to the powerful discourses of the sick and contagious immigrants reproduced in both scientific and public realms (Bell et al., 2006; Eichelberger, 2007; Ho, 2003; Joseph, 1993; Lawrence et al., 2008; Littleton, Park, Thornley, Anderson & Lawrence, 2008; Murdocca, 2003; Washer, 2004). The next chapter explores the role that the Canadian press played and plays in the reproduction of these discourses.

Chapter 4

The role of the media in the (re)production of racism

> *What they (media) exercise is the power to represent the world in certain definite ways. And because there are many different and conflicting ways in which the meaning about the world can be constructed, it matters profoundly what and who gets represented, who and what regularly and routinely gets left out; and how things, people, events, relationships are represented. What we know of society depends on how things are represented to us and that knowledge in turn informs what we do and what policies we are prepared to accept.*
>
> Miller, 2002, p. 246

In the previous chapter I critiqued current immigrant TB control public health policies as an example of institutional racism which perpetuates immigrants' health inequalities. In this chapter I explore the role that the Canadian press has played and continues to play in the perpetuation of institutional racism through the (re)production of racist and racializing discourses. I begin by looking at the role that the advent of print media during the seventeenth century played in facilitating the spread of the ideology of racial hierarchy and nationalism into the European (and later North American) public realm. Numerous examples of the press's representation of immigrants are provided to highlight the role that the Canadian press played and plays in constructing people's knowledge of immigrants as a problem and mobilizing concerned citizens to design policies and enact solutions to deal with this supposed problem. In the second part of this chapter I examine a theory behind media representation studies which can facilitate our understanding of the past and present representations of immigrants in the Canadian press.

4.1 The role of the media in the (re)production of nationalist and racist ideologies

Europe in the seventeenth century was characterized by the territorialization of religious beliefs, the demotion of unifying sacred languages and the decline of sacral monarchies – those chosen and supported by God and the clergy. During this period of secular transformation when the belief in the Divine was on the decline, the fear of fatality was substituted with an idea of nation which gave people the feeling of new continuity and meaning (Anderson, 1991). The idea of nation helped dispersed and unrelated people who did not know each other to imagine themselves as members of the same community for which they were willing to die (Anderson, 1991; Coleman, 2006). In these imagined communities "the nation is always conceived as a deep, horizontal comradeship" between individual members despite the presence of inequalities and exploitation within each communion (Anderson, 1991, p.16).

It was the print media that enabled unrelated groups of people to imagine the nation because reading the same narratives and the same information, "provided the collective imagination necessary for national consciousness" (Coleman, 2006, p.34). In addition, print media provided people with a sense of simultaneity, which was also necessary for imagining the nation. Anderson painted the following, very powerful picture of this simultaneity:

> Newspaper is 'an extreme form' of the book, a book sold on a colossal scale, but of ephemeral popularity. We know that particular morning and evening editions will overwhelmingly be consumed between this hour and that, only on this day, not that… The significance of this mass ceremony – Hegel observed that newspapers serve modern man as a substitute for morning prayers – is paradoxical. It is performed in

> silent privacy, in the lair of the skull. Yet each communicant is well aware that the ceremony he performs is replicated simultaneously by thousands (or millions) of others of whose existence he is confident, yet of whose identity he has not the slightest notion (1991, p.39)

Printed stories and information enabled people to imagine and believe that what unites their presumed communities or nations (and distinguishes them from others) is a common "historic territory, common myths and historical memories, a mass, public culture, a common economy and common legal rights and duties for all members" (Smith, 1991, p.24). In addition, the concept of a national identity provided the nation with meaningful values and frames of reference to which its members could emotionally relate through familiar images of the 'glorious past' such as flags, party labels, legendary events and popular heroes (Bennett, 1997). This new understanding of people's identity also led to the conviction that the members of these new communities were entitled to their autonomous geographic place "in a fraternity of equals" (Anderson, 1991, p.81). The power behind the concept of imagined communities served as a premise to justify a nation's existence and defend its interests (Kostarella, 2007).

Creating imagined communities of equals went hand in hand with imagining the communities of *the Others* who were perceived by the observer (the self) as different and often threatening. Riggins (1997) noted that this discursive construction of othering immigrants appeared, for instance, during the 1995 Quebec independence referendum when immigrants who were not native speakers of either French or English were referred to as the others (*les autres*) while francophone Quebecers were named the people (*le peuple*).

The presence of *the Other* significantly influenced the development of many nations since *the Other* was "perceived to threaten the ethnic and/or cultural purity and/or the independence of the nation" which were usually in close geographic proximity (Kostarella, 2007, p.26). Immigrants thus also constituted an imagined community of *the Other* since before migrating they once occupied an historic territory, shared historical memories and myths, functioned in an economy, adhered to laws and shared a culture believed to be alien to their host nations.

In addition, since the late nineteenth century the imagined differences between people who occupied newly created geographic spaces became biologically and genetically justified on the premises of biological determinism and social Darwinism, according to which, both the bodies and cultures of immigrants were not only deemed *other* but also inherently inferior (McLaren, 1990; Miles & Brown, 2003). As a result of these multiple types of otherness, immigrants were thought of as not belonging to the imagined community. Because the interests and aspirations within particular nations are often defined by commonly shared values such as health, security, stability, justice, peace and progress those who are construed as *the Other* were often projected as not sharing the nation's universal values and norms and therefore threatening its interests and aspirations.

Othering discourses served as a cognitive map to understand who *the Other* (immigrants) are, what they want and how they want it (Fleras, 1994). Said (2003) in his influential work about the representation of persons known as *the Orientals* and geographic space known as *the Orient* showed that these representations were heavily influenced by the language, culture and political background of the representers. The

image of *the Orient* these representers provided responded to socio-cultural, political and economic requirements of their epoch. For several generations of European scholars *the Oriental Other* became merely a subject they could depict, study, judge and discipline in opposition to white norms, values, interests and goals. In other words, those who were presented as *the Orientals* were never allowed to represent and explain their thoughts, emotions, history and presence themselves but they were represented as objects by those who studied them (Said, 2003). And it was "the sense of the normal" of their representers which often served for the evaluation of people known as *the Orientals* (Miles, 1989, p.21).

The representations of *the Oriental Other* proliferated into the general popular culture through body of theory and practice built over several generations. European newspapers also effectively facilitated the dissemination of these representations since the beginning of their mass circulation in the second half of seventeenth century. In these representations, *the Oriental Other* was known as degenerate and uncivilized, "not as citizens, or even people, but as problems to be solved or confronted" (Said, 2003, p.207). However, the emergence of new European nation-states reshaped the representation of *the Other* from an uncivilized savage to that of an uncivilized enemy of the nation.

Miles and Brown (2003) noted that the representations of *the Other* can change "in response to changing circumstances, including the economic and political position of those (re)producing the representations" (p.51). They illustrated this point with the example of the Irish and the Jewish who were construed as inferior races in the past and whose representation changed over time. I agree with the authors that "representations of

the Other are holistically neither static nor unitary" (p.51) but the following sections on the representation of Chinese people in Canada illustrate that the press representation of some non-white non-Europeans is still negative. In the first section I look at the representation of Chinese immigrants between 1860 and 1920 since this historical period was a key moment in the history of developing and implementing Canadian TB control policies. In the second section I look at the representation of Chinese and other immigrants in the Canadian press in the past decade since my study also examines TB reports published in that time period.

4.2 The Chinese Other in the Canadian press: Then

> *They [Chinese] are, with few exceptions, not desirable as permanent settlers in a country peopled by the Caucasian race and governed by civilized enactments. No greater obstacle to the coming of the class of immigrants needed in British Columbia could be devised, than the presence of Chinamen in large numbers.*
>
> The *Gazette*, 1859, cited in Anderson, 1991, p.37

Woodsworth's (1972) description of diverse immigrant groups in Canada (see Chapter 2) has already indicated that since the beginning of immigration to Canada only British and British-like immigrants were attributed positive characteristics. This section illustrates the role of the newspapers in the (re)production of racist discourses and practices. I draw primarily on the example of Chinese immigrants whose immigration experiences of racism and discrimination in Canada's west coast are richly documented and provide a clear example of how immigrant groups have been represented and treated in public realm (Anderson, 1991; Ward, 2002). That said, I recognize that other racialized immigrant groups (Jews to name but one example) were similarly subject to negative

misrepresentation and association with diseases like TB. However, it is neither the intent or within the scope of this thesis to give a comprehensive detailed account of all press reports on all immigrant groups in Canada.

Since the arrival of Chinese immigrants to Canada in the mid-nineteenth century, Canadian society was exposed to accounts of Chinese people who were thought to be ignorant, perverse, cruel and poor (Ward, 2002). These racial stereotypes and prejudices were articulated everywhere where opinions were exchanged: on the streets, in the privacy of homes, at public meetings, in the press and finally, in the legislature. The negative representation of the Chinese was tied to fears about the robust size of the Chinese population and the possibility that Europeans may be overpowered by *the inferior Oriental other* who could change its socio-economic, cultural and political landscape (Ward, 2002). These fears were reinforced in the Canadian press, as this example from the British Columbian (BC) newspaper *Colonist* (1907) shows:

> A struggle is coming beyond any possibility of doubt, and such a struggle as history cannot parallel. The tide-like sweep of the Teutonic tribes across Europe, before which the Roman Empire went down like grass before the scythe, will appear small by comparison with the advance of the Orient when once it has begun in earnest. If the racial assertion of forty millions of Japanese has challenged the astonished Occident, what may we expect when the four hundred millions of China, the two hundred and fifty millions of India and the other people sufficient to swell the aggregate beyond seven hundred millions assert themselves? (Ward, 2002, p.6)

Fears that Chinese immigrants may endanger respectable white Anglo-Saxons and threaten the security and stability of Europe and its colonies were reinforced by the print media in various ways. First, Chinese immigrants were presumed to be the embodiment of disease and a serious threat to health of Canadians with reports that "the Orient was

ravaged by virulent, disgusting diseases" (Ward, 2002, p.7). It was believed that Chinese dwellings were "nests of disease" (Sellar, 2006) where, according to rumours, the Chinese slept three or four to a bed either because they were stingy or degenerate (Ward, 2002). These images of poor and dirty households were regarded as the source of epidemics. Canadians especially feared the epidemics of pestilence, smallpox, cholera, and leprosy which were often associated with Chinese immigrants. Victoria's *Industrial News* (1886) reinforced this belief with reports like this:

> Our dainty Victoria belles are having their fine linen done up today by leprous hands, lepers in whom leprosy may be in a dormant state, or active, but concealed from view, may possibly be at this very hour employed in numbers in a large portion of our would-be aristocratic residences. How long will it take before the pest breaks out? No one knows; the poison may be in the blood of dozens even now (Ward, 2002, p.8).

The news of 'Chinese leprosy' reached also the Canadian east when the *Toronto Mail* (1891) reported: "Word comes from British Columbia that cases of leprosy are being discovered among the Chinese there, and that the loathsome disease is being communicated to the Indians" (Mawani, 2003, p.9). This matter was investigated by the federal Department of Indian Affairs which found that no leprosy has ever broken among the Indians and physicians testifying before the Royal Commission on Chinese Immigration said that leprosy among the Chinese was very rare. Despite this, the newspapers such as the *Colonist* (1899) continued to file reports like this one: "These lepers are all Chinamen…strict provision should be taken to prevent any more lepers arriving in Canada. Every Chinaman should be obliged to pass a medical examination before being allowed to land in this country" (Mawani, 2003, p.9). After years of local press reports fanning fears of the "Chinese disease," the city built a lazaretto on D'Arcy

Island (BC) where 43 Chinese men who were believed to be lepers were confined in dreadful living conditions (Mawani, 2003).

One year after the *Colonist* (1892) condemned Vancouver's Chinatown as "a reeking mass of filth" (Ward, 2002, p.44), several dwellings were denounced and destroyed on the order of the city sanitary officer. The city council authorized the vaccination of all local Chinese (often against their will), and strict disinfection procedures to rid the city of contagions associated with the Chinese. In the mid-1890s, the Vancouver municipal council designated Chinatown as a distinct official entity that was subjected to special sanitary interventions in the same manner as were sewerage, slaughter houses and pig ranches (Leung & Guan, 2004).

Also in Alberta the *Calgary Herald* (1892) appealed to Canadians to boycott Chinese laundry businesses as the presumed sources of diseases so they "may render the stay of Chinamen in Calgary useless and, in a short time, without violence, without any interference with personal liberty, … rid of what the majority regard as an obnoxious element" (Sellar, 2006, p.52).

In addition to diseases associated with Chinese poor living arrangements, Canadians feared diseases they associated with low sexual morals of the Chinese. It was believed that "virtually all Chinese" were infected with syphilis when they entered the country (Ward, 2002, p.9). Chinese women were widely presumed to be prostitutes and concubines as this 1876 report in the *Colonist* illustrates: "Chinese women are in the habit of luring boys of tender age into their dens after dark, and several fine, promising lads have been ruined for life in consequence" (Ward, 2002, p.9).

Fears of ill-mannered and diseased Chinese were later supplanted by the fears of Chinese gamblers and opiate addicts who corrupted native-born men by teaching them to smoke the opium pipes. In addition, the newspaper *Victoria Times* (1908) suggested that "the Chinese opium peddler especially wished to enslave a white woman with the poppy and then defile her with his own embraces or prostitute her to his countrymen" (Ward, 2002, p.9).

The Chinese immigrant was also regarded as a threat to the economic health of the nation. As Ward (2002) noted: "Whites also believed that the Chinese threatened the economic status of the west coast workingman— his wages, his job, and his stable economic environment" (p.10). Therefore the efforts of "a small horde of unemployed Chinamen" to find jobs in Vancouver should be "promptly discouraged" and "[t]he thin edge of the wedge, in this case, had better be obstructed," as *Vancouver News* of 1886 expressed (Anderson, 2008, p.100). The presence of the Chinese immigrants also threatened economic growth by hindering the immigration of white settlers. This desire to get rid of the Chinese immigrant population was evident in *The Cariboo Sentinel* (1875) which stated that it would be

> a delightful relief to both sight and senses not only of residents of Victoria but of visitors, if that pleasant little city could be freed from the forbidding presence and vile habitations of the majority of the Chinese residents, and the comfortable cottages of white laborers, with happy wives and troops of smiling children substituted in their place (Ward, 2002, p.11).

This disdain for the Chinese presence prompted the Mayor of Victoria, Noah Shakespeare, to write a letter in 1882 on behalf of all citizens to the Canadian Government stating that "[u]nless some immediate and urgent steps are taken to restrict

this heathen invasion, the rapid deterioration and ultimate extinction of this Province as a home for the Anglo-Saxon race must ensue" (Ward, 2002, p.11). Such an anti-Chinese sentiment was familiar to Ottawa. Prime Minister MacDonald was quoted saying: "I am sufficient of a physiologist to believe that the two races cannot combine, and that no great middle race can arise from the mixture of the Mongolian and the Aryan. I believe it would tend to the degradation of the people of the Pacific" (Anderson, 2008, p.95). But he downplayed the immigration restriction requests because Canada was in need for cheap Chinese labourers to complete the Canadian Pacific Railway.

By the late 1800s, physical attacks on the Chinese, like the one near Lytton (BC) in 1883, where white construction workers beat nine sleeping Chinese unconscious, killing two of them, were increasing on the west coast. Consequently, to calm this tense atmosphere, the government imposed an immigration head tax, a ban that prevented Chinese from obtaining land in Canada and prevented them from voting in federal elections. Despite these measures, public hatred of the Chinese continued to be expressed at numerous public protests like the one in Victoria in 1885, where the Canadian public demanded that "No yellow slave shall eat our children's bread" and "Cut out the Chinese cancer" (Ward, 2002, p.41).

The Chinese in Canada were increasingly becoming victims of organized anti-Chinese agitation by groups such was *the Anti-Chinese Union, the Canadian Anti-Chinese League* and *Knights of Labor*. These three groups boycotted the prominent white employers of Chinese and called for restricting immigration. Their actions were commended by the *Vancouver News* (1886) which urged its readers to "grapple with the

evil while it is in its infancy" because if city employers did not discharge Chinese in favour of whites, the city would soon deal with "the permanent settlement of the Mongolian" in its midst (Ward, 2002, p.44). The newspaper further threatened that "so long as the Chinaman is encouraged so long will the evil grow, and if allowed to expand as it is now, will develop alarmingly and become so great that the efforts of the people will be powerless to check it" (Ward, 2002, p.44). In the same time, another newspaper, the *Colonist*, reported about diverse forms of racial animosity towards Chinese immigrants. For example, they were discriminated in admission and seating practices in public places such as theatres. Despite paying school taxes, their children were informally discouraged from attending public schools; later segregated schools were formally introduced in 1908. The Chinese were exposed to physical abuse and harassment on the streets.

Newspapers like Toronto's *Mail and Empire* of 1899 published numerous calls for the government to stop the kind of immigration that was converting the Anglo-Saxon empire into an "anthropological garden" filled with "the lost tribes of mankind and the freaks of creation" became more intense yet again (Avery, 1979, p.41). Immigrants were believed to "make Canadians a mixed or coloured race or lower the standards of living, education or morals" (Avery, 1979, p.108). The Canadian government first resisted the pressure. However, after the completion of the Canadian Pacific Railway – the major employer of Chinese immigrants – and upon the recommendation of the Royal Commission, the Canadian government increased personal head tax to $500 in 1903, which dramatically decreased immigration from China (Ward, 2002).

Since 1885, when the head tax was introduced, the federal government had profited and collected about $23 million from Chinese immigrants (Canada in the Making, n.d). This profit, however, was only a weak incentive to sustain the already very limited immigration from China. The Canadian press continued to articulate its resentment towards Chinese immigrants since only "the good seed alone should be allowed to enter and the chaff should be returned to its original dwelling" as *Grain Growers' Guide* of 1914 expressed (Chapman, 1977, p.13). Fears of the Chinese taking jobs from white Canadians during the recession of the 1920s facilitated the governmental decision to pass a law called the *Chinese Exclusion Act* in 1923. Consequently, only 15 Chinese immigrants were allowed into Canada between 1923 and 1947, when the law was finally revoked (Canada in the Making, n.d).

However, the brief stop to Chinese immigration did not stop racism in Canada, because the anti-Oriental consensus very easily extended its influence over two other groups of immigrants known also as *Orientals* who were making their way to Canada since the last decade of nineteenth century (Ward, 2002). Newspapers such as Victoria's the *Colonist* (1900), quickly reflected this new shift in anti-immigrant propaganda, targeting Japanese and Indian immigrants alongside the Chinese: "If we allow this Asiatic deluge to continue much longer, even our law courts and legislature will be given over to the 'heathen Chinese' and the 'little brown men'" (cited in Ward, 2002, p.56). The same newspaper asked: "[A]re we to have this great big province— a land virtually flowing with milk and honey— conserved for the best interests of the white British subject— English, Scotch, Irish, Welsh, etc.—or must it be given over entirely to the yellow and

brown hordes of China and Japan?" (cited in Ward, 2002, p.56). It is beyond the scope of this section to provide detailed press reports on Japanese and Indian immigrants; suffice to say that newspaper content relating to these immigrant groups is very similar to that targeting the Chinese community. Similarly, as newspaper reports contributed to the elimination of immigration from China, they played a role in the restriction of immigration from Japan and India in 1908.

Chinese immigrants who settled in Canada before the enactment of immigration restrictions continued to be negatively represented by the press. Fears of aliens, articulated in the press by the 1920s, mobilized thousands of Canadians to join anti-immigrant groups such as *the Kanadian Knights of Ku Klux Klan*, *the Ku Klux Klan of the British Empire* and *the Ku Klux Klan of Kanada* (Avery, 1979). The role of these groups was to safeguard "all that was admirable in British institutions, Protestantism and the Canadian way of life" (Avery, 1979, p.108). Members of these groups called for a legal ban of mixed race marriages and intimidated couples living in such marriages "for polluting of Caucasian blood", targeting them with property damage and interpersonal violence (Backhouse, 2001, p.11).

The absence of sanctions for expressing racial prejudice facilitated the generation and maintenance of the racist anti-Chinese consensus for almost a century. The heavy racist rhetoric in the Canadian press helped to disseminate anti-Oriental opinions since

> [b]y and large, journalists and orators seem merely to have reflected beliefs already deeply entrenched in the popular mind. For the most part these attitudes circulated through the informal mechanisms of cultural transmission, passed by word and example from resident whites to newcomers and from one generation to another (Ward, 2002, p.168).

In agreement with Miles and Brown's (2003) idea of the dynamic character of representation, the racial consensus about Chinese as steadfast holders of values alien to those of Canadian traditions, laws and institutions has slowly changed with the global changes in international relations and with the changing social and political milieu of Canadian society (Ward, 2002). The expression of overt racism towards racial minorities has been outlawed in Canada, however, more subtle (yet powerful) forms of racist representation of immigrants continue to fill the newspaper storylines.

4.3 The Chinese Other and others in the Canadian press: Now

> *Virtually all of them [Chinese refugee claimants] are wanted crooks or indentured to crooks, or are smugglers. That's why these arrivals should have been jailed.*
> *Montreal Gazette*, 1999

This example of an editorial from *Montreal Gazette* (1999) demonstrates that the rhetoric of the Canadian press about Chinese immigrants is still negative. In fact, in his study of press coverage of Chinese asylum seekers, Greenberg (2000, p.12) found that these migrants were still represented as the "disease-carrying embodiment of danger whose presence poses a significant threat to the moral, physical and economic being of 'legitimate' Canadians" (Greenberg, 2000, p.12). In addition, the press further constructed Chinese as criminals, prostitutes and hindrances to economic development as well as threats to national security (Greenberg, 2000; Hier & Greenberg, 2002).

In addition to the representation of Chinese immigrants as a threat to security and the economy, the contemporary Canadian press continues to perpetuate the discourse of the sick and contagious immigrant. For instance, studying the impact of news coverage of

the SARS outbreak in Toronto in 2003, Leung and Guan (2004) found that the racialization of the infection by associating it with Chinese and Southeast Asians contributed to racist attitudes and practices. By contrast, these racist attitudes and practices were not addressed by the media. Ostracized communities experienced alienation, discrimination and harassment when they were shunned in various public places such as schools, workplaces and public transportation. They often experienced avoidance but also verbal assaults. Some individuals were even evicted from their apartments and lost their jobs. Leung and Guan (2004) concluded that "the contemporary rhetoric of SARS echoe[d] very clearly the historical discourses [of diseased and contagious immigrants] that attempted to contain, regulate and prevent the inclusion of Chinese Canadians and other racialized bodies in Canada" (n.p.).

By the circulation of these discourses in the public realm, stereotypes of Chinese people are, not unexpectedly, still popular in contemporary Canadian everyday discourse. For example, UBC (the University of British Columbia) has been referred to by xenophobic groups using racist tongue-in-cheek humour, as the 'University of a Billion Chinese' ; some university benches have been inscribed with a graffiti slogan stating 'Chinks Go Home'; Vancouver has been nicknamed 'Hong-couver;' and one of Toronto's large multi-cultural neighbourhoods Agincourt was renamed 'Asiancourt.' Hier and Greenberg (2002) correctly remarked that "[s]uch stereotyping sends an unambiguous message regarding who 'belongs' and who does not; more prominently, it speaks to the perceived threat to Euro-Canadian hegemony" (p.160).

The representation of Chinese immigrants reflects certain Canadian geographic zones of xenophobia at certain periods in history. More recently, however, the gaze of the contemporary Canadian press has shifted to Muslim immigrants (the so called *Islamic peril*) (Said, 1997). After the collapse of communism in Eastern Europe in the 1980s, Muslims became known as the primary *Other* in the western world, which was searching for a new threat that could fill the threat vacuum (Karim, 2000). The terrorist attacks on the World Trade Center in 2001 which were presumably committed by Muslims brought Muslim immigrants and their threatening presence in the West once again under the microscope of the western press. News reports constantly portrayed violence as an Islamic norm rather than emphasizing that "no population consistently lives out of its ideals or it is free from those who would twist its beliefs in service of their own desires" (Hodge, 2005, p.167). Karim (2000) argued that by typecasting Muslims into negative roles, the Canadian press fuelled anti-Islamic discourse which consequently justified many anti-Muslim actions such as the imprisonments without known charges, religious profiling, finger-printing, surveillance and deportations that took place in Canada. As of 2009, the coverage of Muslims in Canada continues to be "deeply engrained with stereotypes and misconceptions" (Sharify-Funk, 2009, p.75). Sharify-Funk (2009) showed that in addition to portraying Muslims as a security threat, the media questioned the loyalty of Muslims as being at odds with Canadian cultural norms, specifically Judeo-Christian traditions, secularism, libertarianism and the commitment to women's rights.

In fact, it is often presumed that many immigrants need to learn core Canadian values, which Thompson and Weinfeld (1995) identified as "freedom, liberty, the rule of

law, respect for authority, piety, family, the importance of hard work and education, and civility" (p.195). More importantly, they need to cast off their barbaric customs, as demonstrated in the example of the code of conduct created by the people of Herouxville in Quebec for newcomers intending to settle in their town. This document, disseminated by the *Montreal Gazette*, informed immigrants that they were not permitted to kill women by lapidation, burning them alive, burning them with acid, excising them, infibulating them or treating them as slaves since the people of this town (unlike prospective immigrants) respected women (Heinrich, 2007a).

Similarly, racialized discourses in which immigrants were represented as the embodiment of disease appeared in Canadian news reports on Ebola fever (Murdocca, 2003) and the Chagas disease scare (Kirkey, 2007). In both cases the diseases were largely linked to and blamed on immigrants of foreign (African and South American) origin. Similarly, in the case of HIV/AIDS, the International Gay and Lesbian Human Rights Commission (2000) documented that the Canadian media have heavily stigmatized all immigrants by creating the misleading public perception that HIV/AIDS is an imported problem that can be addressed only by exclusion, rather than by sound prevention efforts. In general, immigrants' health-related issues have often been framed as a crisis of the immigration system that allows sick strangers to penetrate a nation of otherwise healthy, law-obeying and innocent citizens (Hier & Greenberg, 2002; Murdocca, 2003). According to Murdocca (2003), images of the sick stranger represented in the media can mobilize the nation in their logical and well-justified request to secure the national border and thus, be protected from presumed immigration evils. She says that

the national borders symbolize "order, control and cleanliness" (p.26). In other words, by protecting the borders, the nation will be saved.

This account of the representation of immigrants in the Canadian press in the past century shows that although the nature of the threat which immigrants were presumed to pose to Canadians varied, the fact that immigrants pose a threat remains a common thread among these stories and across time. What changes is only the name of the threat and the immigrants' nationalities or ethnicities. One can easily take the original story about the Chinese threat of leprosy and replace leprosy with SARS. Similarly, it is possible to replace the words Chinese and SARS with the words Congolese and Ebola. It is also possible to substitute the name of a disease with such names as terrorism, economic instability or cultural differences. The template has been there for centuries. As Murdocca (2003) aptly put it: "Old threats are often replaced by new threats in the project of nation-building and the discourse of contamination, whether disease or terrorism, seems to rely on similar discursive/national strategies" (p.30). In this work I argue that by representing immigrants according to this age old template 'the old threat with a new name,' the press contributes to the (re)production of racist ideologies and practices. In the following section, I explain the theory behind media representation in order to examine the role that the media play in the (re)production of racist discourses and racism.

4.4 Theoretical framework of discursive media practice

> *When people get sick, or make decisions about health, or visit their health service providers, or decide what to think and vote about health care policy and finance, their behaviour may be formulated in large part from resources drawn from various mass media. These can include depictions of what it is like to be sick, what causes illness, health and cure, how health care providers behave (or ought to) and the nature of health policies and their impact.*
>
> Seale, 2003, p. 514

Gamble and Watanabe (2004) identified that media's role is to dispense information, offer opinions and forums for views exchange, educate and lead campaigns. They also entertain, advertise, provide soil for social interactions and public relations, and inform the public about imminent emergencies. More importantly, however, media are a venue for the (re)producing of discourses which can be studied from two broadly defined perspectives: institutional practice (media production) and discourse practice (media representation and reception) (Fairclough, 2000; Seale, 2003).

4.4.1 Institutional practice (media production)

Studies of institutional practice (media production) examine the actions and inactions of media producers which are heavily influenced by commercial and political environments in which media institutions operate. According to the *gatekeeping theory*, the media are in the hands of powerful individuals who decide, based on their own interests as well as their perception of their audience's wants and needs, which stories are important and which stories will be told (Berger, 1995). Several studies have found that

those powerful decision-making individuals effectively control the representation of ethnic affairs in media (van Dijk, 1995; Henry and Tator, 2002).

Besides these gatekeepers, news stories involving ethnicity are formulated by politicians, managers, and scholars who have controlled access to media discourses by being introduced as major news speakers whose opinions are regularly sought by journalists (van Dijk, 1995). Berger (1995) suggested that the media tell the stories of majorities because "those who perceive their views to be accepted state them ever more strongly, leading to a spiral in which certain views tend to be suppressed and other views gain prominence" (p.152) – the *spiral of silence theory*.

However, it must be mentioned that media are not simply "defenseless victims of political or corporate control and manipulation" (van Dijk, 1995, p.28). They have their own power to define the situation, yet, they do not oppose the prevalent discourses generated by others because they share fundamentally similar ideological positions. As van Dijk (1995) aptly put it: the common ideologies and discourses "are jointly produced, each acting within its own sphere of influence and control, but each also dependent on the other" (p.29).

In addition to the presence of gatekeepers, Kariel and Rosenvall (1995) identified several source and destination filters which influence the process of news-gathering and production. These filters influence what information finds its way to the reader and what information is filtered out. They found the following source filters: First, newsworthy events from smaller cities may be not reported since journalists are usually stationed only in cities with a bigger political influence. Second, reporters usually file their stories only

if they are sure that another newspaper besides their own will be interested in their report. Third, after a story arrives at a news agency, a person decides if it should be transmitted regionally, nationally, or internationally. Fourth, the reports filed in foreign languages may not get published since translation costs newspapers time and money.

The editorial decisions are very important destination filters. As Gamble and Watanabe (2004) found, editors may decide to publish a particular story simply "to increase ratings and circulation," "to keep a reporter in his employer's good graces," or to "support selfish special interests" (p.70-71). Lastly, the size and affluence of a newspaper are also important filters since they control "the amount of news coming into the newsroom and the space available for printing" (Kariel & Rosenvall, 1995, p.31). The wealthier a newspaper is, the more news it can afford to purchase, while the poorer newspapers must rely merely on republishing the news from central outlets.

4.4.2 Discourse practice (media representation and reception)

Discourse practice concerns how the text is communicated (media representation) and consumed (reception studies). These two domains are often intertwined since the positive or negative reception of the communicated discourse can reinforce or change how the communicated discourse will be represented in the future. For instance, the continuous negative reception of discourse which racialized crime in Toronto resulted in the decision to withhold the information about skin colour and ethnicity of alleged crime perpetrators (Henry & Tator, 2002). The purpose of media representation studies, such as is mine, is to examine the language and symbols of the communicated messages in order

to unmask the hidden ideologies. Hall (1999) defined these ideologies as "those images, concepts and premises which provide the frameworks through which we represent, interpret, understand and 'make sense' of some aspects of social existence" (p.271). These ideologies shape the way in which the text is articulated and consumed. The language of the text born out of these ideologies then serves as a tool of socio-cultural production through which people formulate, (re)produce and re(construct) their knowledge of the world as they do through everyday conversation, textbooks, government or scholarly publications, legislation, advertising, and the movie industry (van Dijk, 1995). In other words, media provide an ideological framework for our understanding and interpretation of the world because they "shape our sense of self, our understanding of what it means to be male/female, and our sense of ethnicity, class, race, and national identity. They help us understand who is us and who is them" (Henry and Tator, 2002, p.4).

It is thought that media employ several strategies through which the ideologies are disseminated. Van Dijk (1995) explained that each time people read a news report, "they form a new (or update an already existing) model of that event" (p.14). By an event model he means a mental representation of an experience which is determined by the commonly shared knowledge and attitudes of the social group of the reader. The structure of a model can be influenced by manipulating the significance of certain events, their causes or consequences. According to this *agenda-setting theory*, by focusing on certain issues and neglecting others, media shape people's decision-making processes by telling them what to think about (Berger, 1995).

For instance, in his study of the media influence on public mental health policy in New York, Marcos (1989) noted that the media "determine what information is relevant for the public, create and use experts on the subject through the developments of media personalities, and legitimize or condemn policies through the application of media-based criteria" (p.1187). He also documented that the influential role of the media was exerted "through the manner in which the events are selected, organized, and presented" and also "by focusing on particular positions or by emphasizing certain positive or negative aspects of a policy" (p.1187).

Another very effective communication technique is to deliver the information which appeals to consumers' desire for emotional stimulation. "The audience," as Seale (2003) put it, "seeks emotional stimulation through dramatized contrasts that have an entertaining effect: fear and anxiety" (p.517). Therefore, news and affairs are often dominated by the entertainment agenda that ensures the generation of dramatic effects, which some call *tabloidisation* (Seale, 2003). These dramatic effects can be achieved through several techniques: First, media producers incorporate into their messages sets of *paired polar oppositions* such as healthy and sick, wealthy and poor, masters and slaves, leisure and hard work that give meaning to the text (Berger, 1995). These oppositions allow readers to acquire an understanding of characters and their actions.

Second, journalists make use of *media templates* with an identical order of text elements which generate meaning and trigger certain audience responses (Kitzinger, 2000). These templates serve to develop desired ready-made stereotypes, judgments and interpretations that are later applied by the audience to new stories and narratives. New

stories then become only replicas and "further examples of the original story" (Murdocca, 2003; Seale, 2003, p.519). Russian folklorist Propp observed such templates when he studied the structure of fairy tales. Although the characters and plots of these fairy tales varied, they contained the same order of predictable elements such as the absence of a family member, trickery, villainy, rescue, victory, punishment, a wedding, and so on (Berger, 1995).

Third, Kitzinger (2000) found that once the templates become unpopular, the media needed to employ some new elements. Called *twitches* by Langer (1998) these new elements disrupted readers' expectations. For instance, audience expectations could be disrupted by turning a daily object into a health threat or engaging a character in unconventional activity. According to Seale (2003), the media oppositions, templates and twitches are key ingredients of media health narratives in addition to other typical elements such as the dangers and fears of particular diseases, foods, environments, or medical errors; the fears of villains and freaks who threaten public health; and finally, the stories of victims and heroes.

Studies that examine discourse practice at the reception level are concerned with the impact of media messages on the audiences. According to Berger (1995), these studies can be divided into two streams: studies that say that the media have no impact on consumers because they simply reinforce existing beliefs and values, and studies that consider the media to be a very powerful means of producing and shaping social knowledge. In the past, the audience was considered a passive receptor of mediated messages. According to *the hypodermic theory*, all people were injected by the same

messages as if with a needle they could not resist; according to *the dependency theory*, people became dependent on the media, especially during times of social upheaval and anxiety (Berger, 1995).

The pioneering work of British sociologist Stuart Hall expanded our understanding of the processes around message reception and shifted away from the hypodermic theory. Hall (1980) explains in his essay on encoding and decoding of media messages that the same message can be encoded in more than one way. It can also contain more than one possible reading, and understanding the message can be a problematic process, regardless of how natural it may seem. According to his theory, dominant ideology is typically inscribed as the *preferred reading* in a media text. Audiences decode this reading and adopt different stances based on their different social location. While those whose social location favours the *preferred reading* produce the so-called *dominant reading*, those who inflect the preferred reading to take account of their social position produce so-called *negotiated readings*. *Oppositional readings* are produced by those whose social position puts them into direct conflict with the preferred reading.

Because the media text becomes a vehicle of dominant ideology, it plays an important role in influencing audiences' acceptance of the existing social order, inequalities and oppression (Schroder, 2000). Van Dijk (1995) explains that the *preferred models* "form the core of processes of persuasion, disinformation, and the media control" (p.14). When readers are provided with these preferred models (e.g. negative representation of minorities) over extended period of time, readers will start to reproduce

them, however, they will consider these models to be their "own"(p.14). In van Dijk's words (1995): "[P]ersuasive text and talk are no longer seen as ideological but as self-evidently true" (p.16). In practice, this means that a continuous portrayal of blacks in the role of thieves and murderers leads to viewers' commonsense unquestionable beliefs that blacks are dangerous criminals. These beliefs must be true because, as van Dijk (1991) aptly put it, "You read it in the paper every day" (p.6).

Building on Hall's work, some feminist researchers developed alternative message reception models which locate the audiences in particular histories with certain gender, class, ethnicity, and so on. In these models, media messages operate as cultural products and are understood as "a complex array of competing and contradictory discourses that, while generally reinforcing dominant power relations, often leave room for resistance and contestation" (Walters, 1993, p.736). As Press (1991) demonstrates in her work with American women of different social backgrounds, these women responded differently to inscribed dominant messages. Some resisted, reinterpreted and reinscribed the dominant meanings with their own interpretations.

Research which examines how given audiences actually understand and use popular culture texts can include broad surveys and opinion polls, smaller representative focus groups, or in-depth ethnographic participant observation of a particular audience. Audience analysts investigate how different social groups construct different meanings for the same text. They either look at the effect that the media have on audience (their thoughts and behaviours) or they examine what the audience does with the media presented to them (Schroder, 2000). *The uses and gratification theory* suggests that

people use the media for various gratifications such as relaxation, entertainment, or information. This diversity in gratification along with ability or desire to be identified with portrayed characters are important factors which shape the impact of media messages on an audience (Zurbriggen & Morgan, 2006).

Although readers are no longer regarded as passive receptors, I agree with Henry and Tator (2002) when they say that readers usually subscribe to the ideological position of their favourite media, the one to which they turn "to gain an understanding of not only events but also people, especially those belonging to groups with whom they rarely interact" (p.5). Van Dijk (1991) illustrated this to be true when he found that for the Dutch, who rarely interacted with the Tamils in their country, newspapers were the most important source of information about this refugee community. In addition, most readers "have neither the motivation nor the skills to challenge aspects of their own deeply engrained thought processes" which are characterized by tendencies to think in stereotypical schemes (Henry & Tator, 2002, p.29).

4.5 Summary

In this chapter I explored the role that the Canadian press has played and plays in perpetuation of institutional racism through the (re)production of racist and racializing discourses. I began with the role that the advent of print media during the seventeenth century played in facilitating the spread of the ideology of racial hierarchy and nationalism into the European (and later North American) public realm. I provided numerous examples of press representation of immigrants to highlight the role of the

Canadian press in constructing people's knowledge of immigrants as a problem and enacting solutions to deal with this supposed problem. Lastly, I examined the theory behind media representation studies to facilitate the reader's understanding of past and present representations of immigrants in the Canadian press. Based on the outlined theoretical framework of discursive media practice, I will provide in the following two chapters a critical analysis of discursive strategies which have underpinned the representation of immigrant TB in the Canadian press in the past decade.

Chapter 5

Newspaper background and descriptive statistics of selected articles

As a precursor to examining the discourse of immigrant TB disseminated in the Canadian press, this chapter offers some relevant information about the selected newspaper articles. The first two sections of this chapter identify the recruitment criteria that guided selection of the examined text and offer readers a brief background to the selected newspapers. The third and fourth sections provide statistical data on the status of immigration and TB in the provinces and cities from which the newspapers were selected. The fifth section of this chapter deals with the descriptive statistical data of the analyzed articles; specifically, it concerns news frequency, origin, flow and prominence of the selected publications. Finally, the authorship data are provided. The findings are compared with other relevant studies.

5.1 The identification of the text to be examined

Typically, discourse analysts begin their inquiries by identifying the texts to be examined (Stevenson, 2004). Although the centuries-old media market monopoly of printed press is now shared with the new monopoly of multi-media such as radio, television, Internet and digital media (Peng, Tham & Xiaoming, 1999), I chose to examine traditional print for several reasons: Print media continues to be the powerful venue for communicating news and information and a key source for mainstream consumers. Studies of print media have a well established history with better recognized

analytic systems for examining text than is currently available in other media formats (Ingraham, 2005). Because majority of mainstream mass media advance a similar ideological position and (re)produce similar discourses (Hall, 1980; van Dijk, 1995) it is unlikely that key findings would be lost by limiting the investigation to print media alone, at this historical moment. Also, the stories of local importance published in a particular provincial newspaper may not be seen as significant by the national multimedia broadcasters and therefore not aired (Kariel & Rosenvall, 1995). In addition to these theoretically sound reasons for my choice, there were also practical issues of access. I could easily access newspaper articles at no cost through the university library while the access to the archives of national and provincial multimedia sources could be very expensive. Finally, the examination of discourses in non-print media would require an extensive text transcription.

I chose the following ten newspapers: *Ottawa Citizen* and *Ottawa Sun* (Ottawa); *National Post*, *Toronto Star*, and *Globe and Mail* (Toronto); *Montreal Gazette* (Montreal); *Vancouver Sun* (Vancouver); *Edmonton Journal* (Edmonton); *Winnipeg Free Press* (Winnipeg); and *Chronicle Herald* (Halifax). The circulation details and brief descriptions of these newspapers are provided in section 5.2.

There were several criteria that guided my selection of newspapers. First, two different studies identified the same hierarchy of Canadian cities with respect to news origin, flow and influence: Ottawa, Toronto, and Montreal are at the top level; Vancouver, Edmonton, Winnipeg, and Halifax on the next lower level; and the remaining large urban centres and provincial capitals equally positioned at the lowest level (Kariel

& Rosenvall, 1995; Kariel and Welling 1977). This means that most of the news originated in the large centres and then it was wired to smaller places. Kariel & Rosenvall (1995) found that Ottawa dominated in reporting and disseminating the news about politics and the economy; science, medicine and technology; consumer affairs, and ecology. Toronto took the lead in business and finance, entertainment and the arts, social life, and human interest. Montreal was dominant in sports, law and crime, and news about accidents. Due to the powerful influence of Toronto, Ottawa and Montreal in news production and dissemination, Kariel and Rosenvall (1995, p.155) concluded that

> … readers throughout Canada are far more likely to find news emanating from the three major centres than from centres in their own province or region. This pattern of news origin undoubtedly tends to perpetuate Canadians' lack of knowledge of other parts of the country, to foster their perception that anything worthy of note is happening in a heartland dominated by Toronto, Ottawa, and Montreal, and to reinforce the centralization of power in the hands of few.

Because of what I will refer to as this influence hierarchy, I selected the newspapers published in the seven cities identified above as the most influential in news production in Canada. I expected that reporting on immigrant TB might be on their journalistic agenda since the four provinces (Ontario, Quebec, British Columbia and Alberta) in which eight of the chosen newspapers were published traditionally embrace large numbers of immigrants and also account for the highest rates of TB in Canada.

Second, I chose the major daily newspapers with the highest circulation since these have the potential to reach and influence a large English-speaking audience. Third, since the majority of Canadian newspapers are politically oriented and cater to a specific readership, I chose a diverse range of newspapers (including tabloids) in order to capture

potentially divergent discourses. Fourth, I selected only English newspapers, as I have no working knowledge of the French language which would allow me to analyze French newspapers published in Canada.

I selected articles published between January 1, 1999, and December 31, 2008 because this time frame was characterized by a large immigration of visible minorities to Canada. I assumed that events such as the terrorist attacks of 9/11 in the USA, wars against terrorism in Afghanistan and Iraq, the outbreak of SARS in Toronto, and the issue of reasonable accommodation of cultural differences in Quebec could shape the interests of newspapers to report on immigration-relevant topics. Further, I chose only those articles written about TB within the context of immigrants and not about TB in general. To achieve this, I searched for articles in the Factiva, the LexisNexis and the Newscan.com search engine for newspapers by entering combinations of keywords such as *immigrant(s)* and *TB*, *refugee(s)* and *TB,* or *immigration* and *TB.* In other words, the articles where the word *TB* appeared also contained one of the following search terms: *immigrant*, *immigrants*, *refugee*, *refugees*, or *immigration.* This approach ensured the intersectionality of the topic under investigation: immigrant TB. Then, as I reviewed all the generated articles, I excluded those that were not concerned with immigrant TB in Canada.

I analyzed both 'hard' news such as articles found on the front page and 'opinion' pieces such as editorials, guest columns and letters to the editor. Greenberg (2000) defined the difference between these two types of journalism as follows: "Where 'hard' news purports to be balanced and fair, 'opinion' discourse problematizes the world by

taking up the normative dimension of issues and events as the justification and rationale for taking sides" (n.p). He further explained:

> Editorials are public, mass communicated types of opinion discourse that normally appear in the front section of a newspaper and are the "official" voice of a media outlet on matters of public importance. Op-ed [opinion-editorial] articles are normally placed on the page opposite the conventional editorial and usually represent the expressed opinion of a single individual employed by the newspaper, or by an individual associated with an affiliate news outlet. While op-ed articles are subjective accounts, they are often perceived to carry an *objective-like* status; that is, they are generally, *though not necessarily*, associated with the opinions of the newspaper as an elite institution, since the author is normally a recognized and regular contributor. Guest columns, on the other hand, appear in close proximity to the editorial page and are normally the expressed opinion of an accredited expert or recognized stakeholder outside the media industry, but who nevertheless possesses specialized, "insider" status, for example, a lawyer, physician, NGO, labour leader, or leading academic researcher. (Greenberg, 2000, n,p.)

I chose to examine discourses in both types of reports without consideration of their provenance. I recognize that the placement of discourses within categories "hard news" or "opinion pieces" as well as the relative power and status of their producers may influence the power and trustworthiness of particular discourses and how well these discourses may be receive by their recipients. However, the purpose of my work was to examine what discourses about immigrant health the Canadian press disseminates rather than to investigate the impact of particular discourses according to the section of the newspaper in which they appeared.

5.2 Background information on the selected newspapers

The following pages offer some brief background information about newspapers, from the websites of the *Canadian Newspaper Association* (CNA) and the *Newspaper Audience Databank* (NADbank), as well as from the websites of the newspapers I used. Information on the political leaning of the newspapers (liberal, centrist and conservative) was provided by *Worldpress.org*, a nonpartisan magazine which fosters the international exchange of perspectives and information. Unfortunately, this magazine does not explain which criteria it uses in assigning political orientation to diverse newspapers. In addition, I did not analyze the produced discourses according to the political orientation of the selected newspapers since such an orientation tends to change by time (expressed, for example, through their open support of certain political parties before elections) (Miljan and Cooper, 2003). In addition, published news and reports may reflect the expressed opinions or implicit messages of individual reporters rather than those of actual newspapers and their owners. The statistical data on circulation and readership as well as the information about ownership and political orientation are summarized in Table 5.1.

Table 5.1: Newspapers' circulation, readership, ownership and political leaning

Newspapers	Daily circulation	Weekly circulation	Weekly readership	Ownership	Political leaning
Ottawa Citizen	128,600	900,197	454,600	Canwest	Conservative
Ottawa Sun	39,233	274,628	261,700	Quebecor/Sun	Conservative
Toronto Star	335,680	2,349,760	2,144,300	Torstar	Liberal
Globe & Mail	332,764	1,996,582	999,300	CTVGlobe	Centrist
National Post	197,034	1,182,206	537,700	Canwest	Conservative
Montreal Gazette	151,042	1,057,294	544,200	Canwest	Centrist
Vancouver Sun	176,690	1,060,139	841,600	Canwest	Conservative
Edmonton Journal	119,909	839,365	492,900	Canwest	Conservative
Winnipeg Free Press	127,065	889,457	391,900	Free Press Ltd	Liberal
Chronicle Herald	107,485	752,397	231,700	Halifax Herald	Conservative

1. The *Ottawa Citizen* (OC)

According to its website (Ottawa Citizen, n.d), the *Ottawa Citizen* began its publication as the *Packet* in 1845. For over 160 years it has remained the first choice for news and information in Canada's capital. The newspaper offers in-depth analysis of local, national and international news and events. As of 2009, its owner was Canwest Media and its average circulation was 900,197 weekly and 128,600 daily (CNA, 2009). According to NADbank (2009), the newspaper's total weekly readership was 454,600. The newspaper was considered conservative by *Worldpress.org*.

2. The *Ottawa Sun* (OS)

The newspaper's website (Ottawa Sun, n.d.) states that the *Ottawa Sun* is the youngest of the *Sun* daily tabloids. It began publishing shortly after the *Toronto Sun* Corporation purchased the assets of the *Ottawa Sunday Herald* in 1988. At the time of the study, the newspaper was under the ownership of Quebecor/Sun Media. CNA (2009) reported that the average number of newspaper copies sold was 39,233 daily and 274,628 weekly. Its weekly readership as indicated by NADbank (2009) was 261,700. *Worldpress.org* considered the *Ottawa Sun* a conservative newspaper.

3. The *Toronto Star* (TS)

According to the website (Toronto Star, n.d.), the first edition of the *Evening Star* was published in 1892. In 1899, the paper was purchased by a group of Toronto liberals who appointed Joseph Atkinson as editor. One year later, the paper's name was changed to the *Toronto Daily Star*. In 1903, *the Star* became the first newspaper in the history of Canadian journalism to use wireless news coverage. By 1909, the paper had a circulation of 65,000, which placed it in first place among Toronto dailies. Within 20 years its circulation had risen to 175,000. In 1958, the newspaper was sold to the Atkinson Charitable Foundation. Its name was changed to the *Toronto Star* in 1971 and its current owner is Torstar. According to CNA, in 2009 the average daily circulation of the *Toronto Star* was 335,680. Its weekly circulation reached 2,349,760, which made it the newspaper with the highest circulation in Canada. According to NADbank (2009), about 2,144,300 adult readers read this newspaper weekly. The newspaper was considered liberal by *Worldpress.org*.

4. The *Globe and Mail* (GM)

According to its website (Globe and Mail, n.d.), the *Globe and Mail* was founded by Scottish immigrant George Brown in 1844. It began as a weekly with a circulation of 300, but by 1853 the newspaper had become a daily with a circulation of 6,000. After Brown's death in 1888, *The Globe* was bought by the Jaffray family who controlled it until 1936. During that time the newspaper adopted the label "Canada's National Newspaper" due to its growing influence. In 1936, the paper was sold to financier George McCullagh who also owned the conservative newspapers the *Mail* and the *Empire* and merged them with the *Globe* under a new name, the *Globe and Mail*. After McCullagh's death in 1952, the paper was sold to financier R. Howard Webster who associated it with FP Publications Ltd. In 1979, the *Globe and Mail* became the first newspaper in the world to produce a full text commercial database containing every story from each issue, and the first to publish electronically and in print on the same day. In 1980, when the newspaper came under the control of Thomson Newspapers Ltd., it became Canada's first space-age newspaper by transmitting its editions to the entire country through satellite printing.

While supplying both world and domestic deep analyses, insights and perspectives, the newspaper declared on its website that it believes that "only an informed public can defend itself against power seekers who threaten its freedoms." At the time of the study, its owner was CTVGlobemedia Inc, its average weekly circulation was 1,996,582 (332,764 daily) (CNA, 2008). NADbank (2009) found its weekly adult readership was 999,300. The newspaper was considered centrist.

5. The *National Post* (NP)

At the time of this writing, there was no information about the newspaper on its website. According to *Wikipedia* (n.d.), *The National Post* was founded by Conrad Black from an established financial newspaper, the *Financial Post*, in 1998. The paper was sold in 2001 to Canwest. CNA (2009) reported that the average daily circulation of *The National Post* was 197,034 and the weekly circulation reached 1,182,206. According to NADbank about 537,700 adult readers read this newspaper weekly in 2009. The newspaper was considered conservative.

6. The *Montreal Gazette* (MG)

According to the newspaper's website (The Gazette, n.d.), the *Gazette* is one of the oldest newspapers in North America. Founded in 1778, it began as a French-language paper, but later became bilingual and in 1822 changed to an English-language newspaper. Since the 1960s, the newspaper has had several owners. As of 2009, its owner was Canwest. The website further stated that the *Gazette*, one of Montreal's four dailies, is "the dominant medium for reaching Montreal's large English market." It was estimated that 69% of Montreal's English population turn to the *Gazette* throughout the week. CNA (2009) reported that the average number of newspaper copies sold daily was 151,042 and weekly 1,057,294. According to NADbank (2009), its weekly readership was 544,200. *Worldpress.org* considered the newspaper centrist.

7. The *Vancouver Sun* (VS)

According to the newspaper's website (Vancover Sun, n.d.), the *Vancouver Sun*, a major daily paper in British Columbia, was founded in 1912 and is currently owned by Canwest. CNA (2009) stated that the weekly average circulation of the *Vancouver Sun* was 1,060,139 (176,690 daily). NADbank (2009) reported that its weekly adult readership was 841,600. The newspaper was considered conservative.

8. The *Edmonton Journal* (EJ)

According to the newspaper's website (Edmonton Journal, n.d.), the newspaper was founded in 1903. During its struggle to make a profit while competing with a more successful paper (the *Bulletin*), it changed hands several times. At last, it was bought by the Ontario-based Southam family in 1912. For more than a century, the newspaper has been both an important piece of and "a marvelous record" of Edmonton's history. The newspaper's readership expanded significantly after its competitor, the *Bulletin,* went off press. The *Journal* remained Edmonton's only daily newspaper until 1978, when the morning tabloid the *Edmonton Sun* arrived. The *Journal*'s average circulation was 839,365 weekly and 119,909 daily (CNA, 2009). According to NADbank (2009), the newspaper's total weekly readership was 492,900. The owner was Canwest. Since its founding, the *Edmonton Journal* has openly declared its affiliation with the Conservative Party and its values.

9. The *Winnipeg Free Press* (WFP)

According to the newspaper's website (WFP, n.d.), the *Winnipeg Free Press,* founded in 1872 as the *Manitoba Free Press*, is the oldest newspaper in western Canada. As old as the city of Winnipeg itself, the paper has witnessed and recorded its growth and development "from a muddy Prairie settlement at the forks of the Red and Assiniboine Rivers into one of Canada's leading cities and the capital of a thriving province of more than one million people." The website further stated that for more than a century the *Free Press* has been "the province's leading source of news, information and debate about local matters and ideas, as well as Manitoba's voice on national and international issues." Since 2001, it has been owned by FP Canadian Newspapers Limited, thus becoming the largest independent newspaper in Canada. The newspaper is one of two dailies published in Manitoba. According to CNA (2009), its average circulation was 889,457 issues weekly and 127,065 daily. Total adult readership in Winnipeg was the highest readership in Canada (NADbank, 2009). It was estimated that about 391,900 adults read the Winnipeg Free Press weekly. The newspaper was considered liberal.

10. The *Chronicle Herald* (CH)

According to the newspaper's website (The Chronicle Herald, n.d.), the *Chronicle Herald* has been published in its current form since 2004 when two different and long established Halifax-based newspapers merged. The *Chronicle-Herald*, the older of the two, was founded in 1875, while the *Mail-Star* was started in 1879. Free of membership in a chain of newspapers, the *Chronicle Herald* has been owned since its establishment by its founders, the Dennis family. The website also stated that in addition to delivering

the most comprehensive package of Nova Scotia news, the newspaper also brings national and international stories to its readers. At the time of this study, the newspaper staff was spread across the entire province. CNA (2009) reported that the average daily circulation of the *Chronicle Herald* was 107,485 and its weekly circulation reached 752,397, which made it the largest newspaper in Atlantic Canada. According to NADbank (2009), about 231,700 adult readers read the *Chronicle Herald* weekly. *Worldpress.org* considered the newspaper conservative.

5.3 Immigration statistics in selected provinces and cities

The second criterion that guided my selection of newspapers was the fact that the four provinces (Ontario, Quebec, British Columbia and Alberta) in which eight of the chosen newspapers were published embrace large numbers of immigrants. Therefore, I assumed that the selected newspapers would cover immigrant affairs, particularly in their own provinces. An overview of statistical data on immigrants and visible minorities in the provinces and urban areas in which the selected newspapers are published is provided in Table 5.2. According to Census 2006, 54% (3,362,150/6,186,950) of immigrants identified themselves as visible minorities (Statistics Canada, 2007). Immigration trends show that the majority of immigrants who migrated to Canada in the past decade came from Africa, Asia and the Middle East (see Chapter 1).

Table 5.2: Number and proportion of immigrants and visible minorities in selected provinces and cities in 2006

Province City	Total Population	Immigrants # (%)	Visible minorities # (%)
Ontario	12,028,895	3,516,875 (29.2%)	2,745,200 (22.8%)
Ottawa	801,270	186,430 (23.3%)	161,720 (20.2%)
Toronto	5,072,075	2,396,485 (47.3%)	2,174,070 (42.9%)
Quebec	7,435,900	900,470 (12.1%)	654,355 (8.8%)
Montreal	3,588,520	782,285 (22.0%)	590,375 (16.5%)
British Columbia	4,074,385	1,170,145 (28.7%)	1,008,855 (24.8%)
Vancouver	2,097,965	870,470 (41.5%)	875,300 (41.7%)
Alberta	3,256,355	554,130 (17.0%)	454,200 (14.0%)
Edmonton	1,024,820	198,635 (19.4%)	175,295 (17.1%)
Manitoba	1,133,515	158,780 (14.0%)	109,095 (9.6%)
Winnipeg	686,040	127,175 (18.5%)	102,940 (15.0%)
Nova Scotia	903,090	48,595 (5.4%)	37,685 (4.2%)
Halifax	369,455	29,615 (8.0%)	27,645 (7.5%)

5.4 Incidence of active TB in selected provinces

Since 1986, the highest proportion of TB in Canada has been consistently attributed to the immigrant population, ranging between 62–68% in the past decade, as shown in Figure 3.1 (Chapter 3, Section 3.3). During this period, about 70–80% of all active TB cases were diagnosed in Ontario, Quebec, British Columbia and Alberta (PHAC, 2008a). The foreign-born population usually accounted for approximately 60–70% of these cases (PHAC, 2008a). Since people are typically diagnosed in the province

where they reside, I assumed that the Canadian newspapers published in these four provinces would be more likely to cover the problem of immigrant TB. Since PHAC does not provide statistics on the incidence of TB in particular metropolitan areas, they could not be included in this analysis. Data collected from 1999 to 2007[9] show that the proportion of TB in immigrants in Ontario (ON), Quebec (QC), Alberta (AB), British Columbia (BC), Manitoba (MB) and Nova Scotia (NS) maintains, in general, the same levels (see Table 5.3 and Figure 5.1).

Table 5.3: Proportions of immigrant TB in the selected provinces

Provinces	1999	2001	2003	2005	2006	2007
Ontario	85%	81%	88%	85%	84%	89%
Quebec	57%	53%	65%	59%	63%	62%
Alberta	60%	63%	66%	80%	70%	75%
British Columbia	74%	75%	75%	76%	72%	71%
Manitoba	27%	29%	17%	26%	18%	27%
Nova Scotia	n/a	n/a	33%	71%	40%	49%

While in ON and QC the proportion of immigrant TB slightly increased by 4-5% since 1999, in AB the proportion increased by 15%. In BC, the proportion slightly decreased by 3% since 1999. In MB, the proportion of immigrant TB fluctuated between 17 to 27% but the 2007 level was the same as that of 1999.The NS data must be interpreted with

[9] The data for 2008 and 2009 had not been releases at the time of this writing.

caution for two reasons: 1) no specific information about NS was collected until 2003; 2) the incidence of TB in NS was consistently among the lowest in Canada until 2007, (only six to ten cases annually out of which two to five cases were foreign-born). A conversion of these low numbers to proportions skews results and conveys an inaccurate picture about the immigrant TB situation in NS.

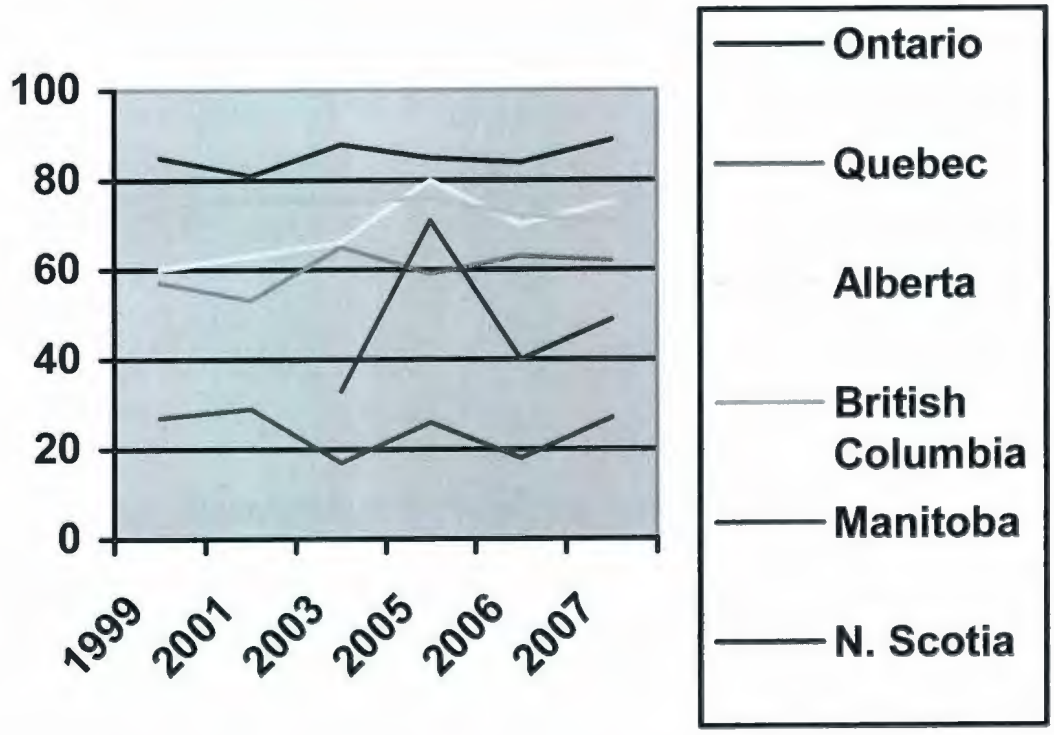

Figure 5.1: Proportions of immigrant TB in the selected provinces

It is apparent that since 1999 immigrants have represented the largest proportion of all cases in ON, QC, BC and AB. The proportion of cases in MB has been much lower since the highest burden of disease was consistently carried by Manitoba's Aboriginal

population (PHAC, 2008a). As noted, the incidence of immigrant TB in NS was consistently very low. Therefore it is interesting to compare the coverage of immigrant TB in provinces with a high burden of immigrant TB and those with a low burden. It is also worthy to investigate whether these low rates might be explained by a different socio-economic profile of immigrants living in MB and NS. Such information could contribute toward better understanding of the etiological reasons underlying immigrant TB.

5.5 Descriptive statistics of the analyzed articles

5.5.1 News frequency, origin and flow

Based on my selection criteria, I selected 273 articles which were then coded in chronological order according to the name of the newspaper and the date they were published (see Appendix 4). The largest number of relevant articles published between January 1, 1999, and November 30, 2008 was found in *Toronto Star* (n=50) and *Globe & Mail* (n=46) followed by *Montreal Gazette* (n=31), *Ottawa Citizen* (n=28), *National Post* (n=25), *Edmonton Journal* (n=25) and *Ottawa Sun* (n=20). *Chronicle Herald* published 16 articles. The fewest number was published by *Winnipeg Free Press* (n=12) (see table 5.4). These data confirmed my assumption that the issue of immigrant TB was, in fact, covered by the selected newspapers during the time period discussed above.

Table 5.4: Newspaper articles count

Newspapers	Newspaper articles count 1 Jan 1999 – 31 Dec 2008										
	99	00	01	02	03	04	05	06	07	08	Total
Ottawa Citizen	7	8	4	1	5	0	2	1	0	0	**28**
Ottawa Sun	10	4	3	2	1	0	0	0	0	0	**20**
Toronto Star	16	10	5	8	1	3	1	5	0	1	**50**
Globe & Mail	21	13	6	4	1	0	0	1	0	0	**46**
National Post	4	4	7	3	3	1	0	2	1	0	**25**
Montreal Gazette	9	12	1	3	2	0	0	3	1	0	**31**
Vancouver Sun	6	6	2	3	2	0	0	0	1	0	**20**
Edmonton Journal	0	9	4	2	2	2	0	0	4	2	**25**
Winnipeg Free Press	5	1	2	0	2	1	1	0	0	0	**12**
Chronicle Herald	7	4	1	2	2	0	0	0	0	0	**16**
Total	**85**	**71**	**35**	**28**	**21**	**7**	**4**	**12**	**7**	**3**	**273**

The trend of uneven distribution of immigrant TB among the provinces was reflected by the fact that the number of relevant articles published in ON, QC, BC and AB was much higher (n=245; 90%) than the number of articles published in NS and MB (n=28; 10%). Moreover, 85% (n=233) of all articles studied dealt with the issues relevant to immigrant TB in ON, QC, BC and AB. Newspapers in these four provinces reported on immigrant TB either from the national perspective using national data or from the provincial and urban perspective offering information most relevant to their respective location. While, on some occasions, they published information relevant to immigrant TB in all four provinces, these newspapers did not report any information about the TB

situation in MB or NS. Table 5.5 shows that while some newspapers relied mainly on information that originated from their respective locations (local reports), others relied on news transmitted from elsewhere (wired reports). For instance, in Chronicle Herald only one article originated locally in NS while 13 other articles were wired from other provinces. Readers in NS were thus offered information about the immigrant TB situation occurring elsewhere while very little information about their local situation was provided to them. In addition, the most wired reports originated from ON (in particular from Ottawa) followed by those which originated from Montreal (see table 5.6).

Table 5.5: News origin

Newspaper	Dateline		
	Local	Wired	Not stated
Ottawa Citizen	18 (64%)	6 (21%)	4 (15%)
Ottawa Sun	12 (60%)	7 (35%)	1 (5%)
Toronto Star	32 (64%)	14 (28%)	4 (54%)
Globe & Mail	20 (44%)	18 (39%)	8 (17%)
National Post	19 (76%)	6 (24%)	0
Montreal Gazette	18 (58%)	13 (41%)	0
Vancouver Sun	10 (50%)	8 (40%)	2 (10%)
Edmonton Journal	13 (52%)	10 (40%)	2 (8%)
Winnipeg Free Press	9 (75%)	3 (25%)	0
Chronicle Herald	1 (6%)	13 (81%)	2 (13%)
Total	**152 (55.7%)**	**98 (35.9%)**	**23 (8.4%)**

Table 5.1: News flow by origin

Dateline	Number of transmitted articles
Ottawa (ON)	31 (31.6%)
Montreal (QC)	18 (18.4%)
Hamilton (ON)	13 (13.3%)
Toronto (ON)	10 (10.2%)
Vancouver (BC)	9 (9.2%)
Trenton (ON)	2 (2%)
Gold River (BC)	2 (2%)
Victoria (BC)	1 (1%)
Kingston (ON)	1 (1%)
Kitchener (ON)	1 (1%)
Cold Lake (AB)	1 (1%)
St. Catharines (ON)	1 (1%)
Collingwood (ON)	1 (1%)
New Brunswick	1 (1%)
International	5 (5.1%)

These data on news origin and flow displayed in Table 5.5 and 5.6 are consistent with Kariel and Rosenvall's (1995) finding about news production among Canadian cities with Ottawa, Toronto and Montreal at the top of the influence hierarchy. By this I mean that residents in cities lower on the influence hierarchy tended to receive news about immigrant TB issues produced by journalists in cities higher on the influence hierarchy. Conversely, readers in Ottawa, Toronto and Montreal were less likely to be informed

about the immigrant TB situation in smaller centers. Therefore they might not know that TB rates within the immigrant population are low in MB and NS.

5.5.2 News prominence measurements

Some researchers engaged in newspaper content studies employ news prominence measurements such as day of week, page of item, location on page, headline size, text size and analysis of photographs, since these factors may influence the attention that readers pay to certain news items (Westwood & Westwood, 1999). For the purpose of this study which is concerned with representation analysis, the analysis of these measurements was secondary. For discourse analysis, the prominence of an article is less important than the content of textual macro-elements (such as subjects and topics) and links this content to broader social, political or historic context. For the same reason, editorials are just as important as "scientific" reports. Knowing the position of the article or the headline size is, therefore, less informative in my data analysis.

I showcase only the list of newspaper sections in which the selected news items about immigrant TB were printed as it is relevant to my critique of TB coverage. More than half (n=147; 54%) of the 273 selected articles were located in the section *News* while 25 articles (9%) could be found in the section *Editorial* and *Opinion* (see Table 5.7). There were 17 (6%) *Letters to the Editor* published in the selected period, which shows that the issue sparked some interest among newspaper readers. Interestingly, 11 articles (4%) were published in the section *Business* (including 9 articles published in the *Financial Post*), while only 3 articles (1%) appeared in the section *Health.* The relatively

high number of brief news reports and the relatively low number of in-depth insight or special reports is problematic since brief news cannot deliver the full portrayal of post-migration experience. Such a full portrayal is necessary for a better understanding of the immigrant TB problem. Although it is beyond the scope of this research to draw conclusions about the lack of information provided in brief news reports, it seems reasonable to assume that readers may have insufficient information about the underlying determinants of the immigrant TB problem in Canada.

Table 5.2: The article count by newspaper section

	Newspapers										
Section	**OC**	**OS**	**GM**	**TS**	**NP**	**MG**	**VS**	**EJ**	**WFP**	**CH**	**Total**
News	20	12	31	42	4	21	14	3	0	0	**147**
Editorials Opinions Commentary Column	0	3	6	1	1	5	5	5	0	3	**29**
Letters to the Editors	0	4	6	2	1	0	0	3	1	0	**17**
Reports Reviews Focus	0	0	2	1	0	2	0	0	0	0	**5**
Business Finances	1	0	0	0	9	1	0	0	0	0	**11**
Health	0	1	1	0	0	0	0	0	1	0	**3**
Other*	7	0	0	4	10	2	1	14	10	13	**61**
Total	28	20	46	50	25	31	20	25	12	16	**273**

*In order to simplify the table, I combined similar sections together. The sections which I could not combine together are included under Other. It is possible that the sections under Other could be considered either news, editorials or reports but their names such as, for instance, Metropolitan, Canada, Life, CityPlus, TopCopy, etc. did not allow for linking them with the sections explicitly identified as News or Editorials.

5.5.3 The authorship data

This section provides information on the authorship of selected articles (see Table 5.8). A total of 121 authors were identifiable in the 273 selected articles. Some of these authors contributed to more than one newspaper. Eight articles were co-authored. The majority of the authors were news reporters or columnists associated with a particular newspaper, reporters working for the Canadian Press or the Parliamentary Bureau, and freelance writers. Four authors were identified as health reporters and several letters to the editor were written by medical doctors. In 75 of the articles, no author was identified. That such a large number and variety of authors (re)produced the same discourses (identified in Chapter 6) supports the idea that discourse producers (including editors who chose these articles) advance a similar ideological position (van Dijk, 1999).

Table 5.3: The authorship of analyzed articles

Newspapers	Authorship		
	# of authors	# of co-authored	Not stated
Ottawa Citizen	21	1	6
Ottawa Sun	9	0	7
Toronto Star	24	0	17
Globe & Mail	29	2	7
National Post	13	1	4
Montreal Gazette	20	3	9
Vancouver Sun	13	1	5
Edmonton Journal	13	0	10
Winnipeg Free Press	8	0	3
Chronicle Herald	9	1	7

5.5.4 Frequency trends and prominence of stories

Interestingly, there is a common trend in the selected newspapers: the number of relevant articles about immigrant TB significantly decreased during the past decade (see Table 5.4). The highest number of articles were published in 1999 (n=85) and 2000 (n=71), while between 2001 and 2003 the number ranged from 35 to 21. Since 2004, the number of published articles has dropped to 4–12 items per year, while in 2008 the selected newspapers published only a total of 3 articles, a 28-fold decrease since 1999. This trend is shown in Figure 5.2.

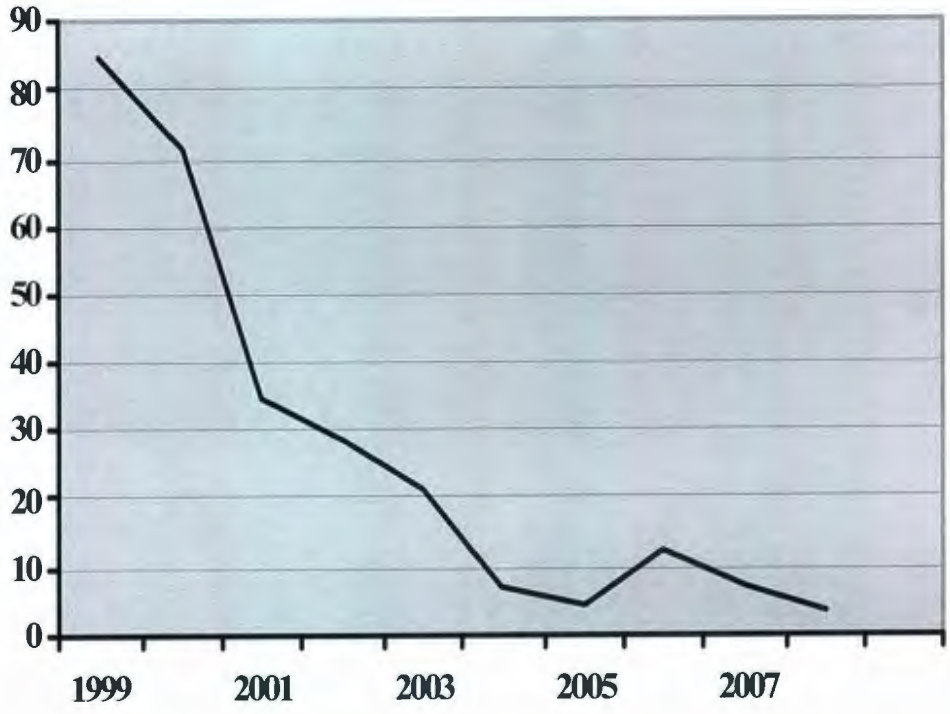

Figure 5.2: Decreasing frequency of published articles between 1999 - 2008

One would assume that since the proportion of immigrant TB cases was consistently on the rise in Canada in the past decade (see Figure 3.1), the frequency of articles about immigrant TB would be increasing. In fact, the reverse is true. The decreasing frequency of the news about TB may be explained in several ways. Prior to elaborating on these reasons, I offer a brief overview of the story topics with a more detailed discussion of the embedded discourses to follow in Chapter 6.

1999:

- the arrival of Kosovar refugees in Canada who were accused of exposing to the infection Canadian flight attendants, volunteers and soldiers working at refugee camps
- the arrival of boatloads of Chinese illegal migrants suspected of carrying TB
- the story of a Vancouver physician exposed to TB after resuscitating a Burmese refugee with active disease
- the arrival of Tibetan refugees diagnosed with multidrug resistant TB

2000:

- the story of a Peruvian refugee who was on trial for non-compliance with treatment for multidrug resistant TB
- the story of an immigrant from the Dominican Republic who, due to a misdiagnosis by an immigration physician, lived for one year in Canada with undetected multidrug resistant TB, thereby exposing hundreds of people in Hamilton and Toronto to his disease

2001:

- the study published by Queen's University identifying the gaps in the immigrant medical surveillance program
- public health reports from Toronto indicating the lack of finances to develop and run TB prevention programs

2002:

- the second study published by Queen's University on the gaps in the immigrant medical surveillance program

2003:

- the Auditor General's report on the insufficiencies in the immigrant medical surveillance program

2004:

- the story of a Bangladeshi man with active TB who escaped from a hospital in Toronto

2006:

- the story of an immigrant from Haiti with active TB who infected drug trial volunteers in a pharmaceutical facility in Montreal

In 2007 and 2008 the trend was the lowest and no sensational stories of TB spread to Canadians were noted.

The list of prominent topics which made the news between 1999 and 2008 indicates that the newspapers informed readers about the problem of immigrant TB mainly through the sensational (but rare) incidents of disease exposure to native born

Canadians and through official reports criticizing the loopholes in the TB monitoring system. This is consistent with the findings of Berlant (1991) who said of the media that the lives of marginalized groups are usually invisible until they "enter the national register through stereotype, scandal or unusually horrible death" (p.180). One might speculate that the slow disappearance of TB stories from the Canadian press agenda despite the persistence of the immigrant TB problem in Canada (as discussed in section 5.4), was related to the absence of scandal or horrible death during that time.

Just as plausible is that news about the immigrant TB problem was less visible in Canadian newspapers because other events were making headlines nationally and internationally during the past decade. Chapter 4 has already illustrated how new stories can be replicas of the old stories, such as when the original story of the Chinese threat of leprosy becomes the new story about the threat of Congolese Ebola. Thus, it is possible that the old story of the immigrant TB threat becomes the new immigrant threats of terrorism, SARS, and cultural differences. In each case the template of the diseased contagious immigrant threatening the health of non-immigrant population is the consistent theme. As Murdocca (2003) says, "Old threats are often replaced by new threats in the project of nation-building and the discourse of contamination, whether disease or terrorism, seems to rely on similar discursive/national strategies" (p.30). Thus, the significant drop in the frequency of published articles in 2001 may be explained in a couple of ways.

First, Sharufy-Funk (2009) and Karim (2003) found that there was widespread reporting about the threat of terrorism presumably posed by some immigrant groups after

the destruction of the World Trade Center in New York, the damage to the Pentagon in Washington, and a series of alleged terrorist plots against several western countries, including Canada, during the time frame bracketed by my research.

Second, the drop in the number of publications in 2003 may be explained by the greater focus on the threat of SARS in Canada (Leung & Guan, 2004), an infection that was associated mainly with immigrants and travellers from China, where the SARS infection is said to have originated. Similarly, in 2006 and 2007, Canadian newspapers reported on the issue of reasonable accommodation of cultural values, customs and practices after a series of incidents occurred: for example, some girls and women were prevented from participating in sports events (CBC, 2007), education and employment (Helly, 2004) due to their headgear, and a controversial code of conduct was issued for immigrants in Hérouxville, Quebec (Heinrich, 2007a).

Although it is possible that the decrease in the number of published reports about immigrant TB may be attributed to an increased focus on other perceived threats to health, security and nationhood, this would require further in-depth quantitative and qualitative content analysis of all relevant articles, which is beyond the scope of this research project.

Chapter 6

Critical discourse analysis of TB press coverage

The previous chapter offered some background information on selected newspapers and descriptive statistical data about news frequency, origin, flow and their prominence. This chapter explores the discourses about TB, immigrants and their health that the Canadian press (re)produced in the past decade by answering the following four domains of inquiry which became evident as I read and reread the articles:

1. What information was offered about the biomedical character of immigrant TB?,
2. What information was provided about the consequences of TB to Canadians?,
3. What information was given about immigrants and their health?, and
4. What information was presented about the solutions for immigrant TB in Canada?

A brief discussion on sources and quotations used in the analyzed text is also included. I identified the topics and subtopics in all of the selected articles and indexed them. For example, the topic "Canadian *victims* of infection" – MG7 means that this topic can be found in the *Montreal Gazette* in Article #7. Then I organized the topics around the four main domains of my inquiry identified above. Lastly, I placed these topics into relevant tables which also provide information on the frequency of these topics and the patterns of reporting trends for each selected newspaper. If a new topic emerged in a certain newspaper, I double-checked all previously analyzed newspaper articles to ensure that I did not miss this new topic in previously analyzed materials. I illustrate the identified topics by the most relevant newspaper quotes.

6.1 Critical discourse analysis of TB coverage in the Canadian press

Newspapers framed the problem of immigrant TB in Canada by offering information about the biomedical character of immigrant TB and the consequences of TB infection to Canadians. Newspapers also reported on immigrants coming to and living in Canada, and, lastly, they presented solutions for the immigrant TB problem.

6.1.1. Biomedical character of TB

Newspapers used different means to present the biomedical character of TB which I have classified as: epidemiologic trends, the natural history of TB, and treatment and prevention. The frequency of occurrence of these topics for each selected newspaper is displayed in Table 6.1, which is followed by a qualitative interpretation of these data.

Epidemiologic trends

Epidemiology studies the factors that determine and affect the frequency and distribution of disease and its causes in a defined population (CDC, 2006). About 38% (n=104) of the 273 selected articles offered some statistical information on TB prevalence, incidence and mortality in the world as well as on the incidence of TB in Canada in general or in high-burden provinces and urban areas in particular. Some articles also provided Canadian immigration statistics and data about the incidence of TB among the immigrant population. Although the statistical data can give readers a better idea about the magnitude of the TB problem nationally and worldwide, some readers may have difficulty in interpreting these data as presented in newspaper accounts.

Table 6.1: Biomedical character of TB by each newspaper

Newspapers											
Category/ Topic	**OC**	**OS**	**GM**	**TS**	**NP**	**MG**	**VS**	**EJ**	**WFP**	**CH**	**Total**
Epidemiologic trends											
Statistics	10	3	21	21	13	8	5	10	9	4	**104 (38%)**
Low rates in Canada	2	0	6	3	1	2	1	4	1	1	**21 (8%)**
Past problem	2	1	2	3	4	2	2	1	1	2	**20 (7%)**
Presence in other populations	1	1	10	9	1	1	3	6	5	1	**38 (14%)**
Imported disease	8	2	8	12	7	21	9	11	8	5	**91 (33%)**
Fight overseas	3	0	5	3	0	4	2	7	1	2	**27 (10%)**
Latency period	2	0	1	1	4	0	1	0	0	0	**9 (3%)**
Poverty (world)	1	0	1	1	0	1	2	3	3	0	**12 (4%)**
Poverty (Canada)	1	0	8	5	1	1	2	1	4	0	**23 (8%)**
Poverty (immigrants)	0	0	5	1	0	0	1	1	1	0	**9 (3%)**
Natural history of TB											
Spread	3	4	5	14	2	4	4	3	1	3	**43 (16%)**
Manifestation	2	0	2	4	2	2	1	0	2	0	**15 (6%)**
Low contagiousness	2	0	3	6	3	0	2	0	1	1	**18 (7%)**
Treatment & Prevention											
Preventable	4	0	5	1	0	0	3	3	1	1	**18 (7%)**
Treatable	9	2	19	17	9	1	6	6	5	1	**75 (28%)**
Curable	1	0	6	4	0	2	0	1	2	0	**16 (6%)**

It is unfortunate that only 8% (n=21) of the articles explicitly mentioned that the rates of TB prevalence, incidence and mortality in Canada are among the lowest in world.

Approximately 7% (n=20) of the articles framed the problem of TB as a serious problem of the past which has been "nothing but eliminated from Europe and North America" (MG26, 28/05/03), "virtually eradicated in Canada" (TS 21, 3/12/00), or "once thought conquered" (GM14, 22/09/99). Stating that TB was eliminated from Europe and North America ignores the existing differences in the burden of TB between individual European countries and within different population segments of Europe and North America. These differences largely shadow the socio-economic standards in these countries (WHO, 2005), as was described in Chapter 3.

For instance, TB has never ceased to pose a serious problem to the Aboriginal population, which accounts for 20% of the disease burden in Canada (PHAC, 2008b). In addition, in the Yukon, Nunavut and the Northwest Territories, the rate of 102 cases per 100,000 among the Inuit people is comparable to the average TB rate in two low-income WHO regions: the Eastern Mediterranean and the Western Pacific (WHO, 2009). Only 14% (n=38) of the articles informed readers that TB is present in Canada and poses a problem for other groups of people besides immigrants. These groups included Aboriginals, the homeless, the poor and those with HIV/AIDS. One article, for instance, indicated that "in some northern communities, up to half of the [Aboriginal] population is infected (TS47, 25/03/06)."

Framing TB as a disease of the past, a recently "resurrected killer" (EJ8, 07/12/00) while ignoring its continuous presence among disadvantaged groups in Canada

and other western countries contributes to misinformation about the TB problem and the reasons for its persistence. This lack of awareness was indicated by one article quoting Wherrett's (1977) words: "One hundred years ago the word consumption struck terror in human hearts… Today, in the western world, it barely evokes any emotion save a too easy surprise that it still exists" (OC9, 30/04/00). Canadian newspapers' assertion that "TB is back" is problematic as it ignores that some people are marginalized by TB all their lives (Ott, 1996).

If TB is represented in the news as being back, one must logically search for the reasons for its resurgence. Almost 33% (n=91) of the selected articles suggested that TB is an imported exotic disease, "the gift an open world holds for our future" (TS11, 03/10/99), brought to the country by immigrants and travelers (see Figure 6.1). Numerous articles had similar comments: "With tourism, international travel, migration and [the number of] refugees on the rise," Canada is no longer a safe haven (EJ13, 24/03/01); "'Everyone who breathes air' should worry about the risk of contracting TB because of travel and migration" (VS16, 21/11/02); "With the increase in international travel and immigration, it would be foolhardy to think that Canada is safe from the threat of TB (MG13, 16/06/00)"; "When people from developing or Third World countries immigrate to Canada or Canadians travel abroad, they can bring the disease to Canada" (EJ12, 24/03/01); and finally, "We are no longer immune to the diseases of the developing countries (TS14, 10/10/1999)."


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TB's deadly comeback

How tuberculosis, once thought vanquished, could make a dangerous return thanks to immigration and the dismantling of our health-care defences

By Megan Ogilvie
Story, A8

Figure 6.1: The *Sunday Star* cover (2008)

The notion that TB is "a disease of the developing countries" which is being imported to Canada by travel and immigration was reinforced by coverage about fighting TB overseas. Ten percent (n=27) of the articles included messages such as "We will

never eliminate TB in Canada unless we do more to eliminate the disease in poorer countries where most of the cases are coming from" (EJ2, 24/03/00); "We can't solve Canada's TB problem, until we solve the world's" (GM43, 18/05/02); and "To protect ourselves locally, we must act globally" (TS34, 15/03/02). The notion that TB is an imported disease and that the solution to its problem lies in eliminating the infection in low-income countries once again ignores the reality that TB poses (and likely will continue to pose) a problem to other non-immigrant populations in Canada such as Aboriginals, prisoners, injecting drug users and the homeless, regardless of Canada's effort to fight TB overseas.

The association of the TB problem in Canada with immigration was reinforced by yet another disease pattern that newspapers failed to report. As indicated in Chapter 3, immigrants (with the exception of some refugees) do not arrive in Canada with active TB but develop the disease several years after immigration. This latency period can vary between 2–14 years (Cowie & Sharpe, 1998; Kerbel, 1997; Public Health Research and Evaluation Division, 2000) with 41% of cases appearing five years after arrival (PHAC, 2007). However, only 3% (n=9) of all selected articles informed readers about the existence of the latency period. The absence of this important piece of information reinforces the notion that immigrants bring in contagious TB at the time of their arrival. This can be evidenced by one letter to the editor in which a reader called for a compulsory detention of all landed immigrants and refugees for a period of six weeks after their arrival by stating "Lock them up!" (OC19, 02/10/01).

With respect to the risks of contracting and developing TB, only a few articles identified socio-economic reasons among the risk factors or regarded TB as "a disease of poverty" that "preys on marginal populations, on the weak and the sick" (GM43, 18/05/02) regardless of their immigration or citizenship status. In fact, only 4% (n=12) of the articles identified poverty-ridden social and living conditions as risk factors for developing active TB in low-income countries. Only 8% (n=23) associated similar risk factors with active TB among the non-immigrant population of Canada. For example, one article stated that "crowded living conditions, poorly ventilated shelters, and people whose immune systems have been sapped by hunger and hard living present a fertile field for infection" (TS42, 29/11/04). Still another one reported that "the disproportionately high rates of TB among aboriginals underlies the fact of life many Canadians would rather not confront – life for many North American aboriginals is similar to life among those living in the world's poorest countries" (OC9, 30/04/00). Another article noted that "the desperate poverty of the Downtown Eastside [Vancouver] has created the type of closely confined, unsanitary conditions where TB most easily spreads" (VS2, 13/01/99).

However, most of these articles made the connection between poverty and the non-immigrant population only. The link between immigrants and the poverty surrounding their post-migration experience was made by only 3% (n=9) of all articles. One article said that immigrants can be found among the homeless who prefer to sleep in front of City Hall and on the streets [of Toronto] because the overcrowded and violent shelters are ridden with TB and other infections (TS44, 01/26/05). Another article described the post-migration experience in Canada this way:

> The promised jobs don't exist; their [immigrants'] qualifications are not recognized; employers demand Canadian experience which they can't get; the racial discrimination is obvious. And when they run out of resources or places to go for help, they have nowhere to turn to... (TS35, 30/03/02)

While three articles stated that post-migration stress can reactivate TB, only one article articulated a clear connection between the post-migration experience and the problem of TB among immigrants by stating that the high burden of TB among this population "does not mean that immigrants and refugees bring TB with them" (GM5, 07/05/99). This article explained that "the conditions newcomers live under when they come to a new country may be as important as prior exposure to pathogens in explaining any tendency to develop illness." The article offered an example of immigrants in New York at the beginning of the twentieth century who suffered from a high burden of TB "not because they were sick when they arrived, but because they were forced to work in badly ventilated workshops, ate a poor diet and lived in overcrowded tenements." The lack of similar information linking a post-migration experience of poverty with the development of active TB strongly reinforces the discourse of TB as an imported disease that presumably sick immigrants bring from their birth countries to Canada when they arrive.

Natural history of TB

The natural history of disease is understood in medical books as disease spread and manifestation. From a biomedical perspective, this information is very important as it can educate people about how to stay protected from disease and how to recognize its symptoms in order to seek early treatment. I found that only 16% (n=43) of the articles

provided information about the ways in which TB can be transmitted and only 6% (n=15) of the articles listed TB symptoms, often incompletely. Only 7% (n=18) of the articles stated explicitly that TB is not a highly contagious infection, meaning that the risk of exposure to infection increases only with prolonged time spent in close contact with a person who has active disease. On the contrary, some articles erroneously stated that TB was a highly contagious disease that could be contracted after a brief contact with the infected in subways, airplanes and restaurants.

In addition, only some articles made a distinction between the latent (non-contagious) and the active (contagious) forms of TB. Statements such as "...flight attendants who worked on flights that ferried Kosovar refugees to Canada have contracted TB...(TS6, 27/09/99)" and "Kosovo flight attendants got TB (MG7, 28/09/99)" or "Man with deadly TB infects 35" (EJ6, 05/12/00) obscured whether these people simply tested positive for latent TB or actually developed active disease. In addition, the articles neglect to point out that those who tested positive for TB could have been exposed to TB prior to being in contact with Kosovar refugees. In some instances when articles did make the distinction between these two forms of infection, they did not provide accurate information about latent TB. The statement "...this time she [a Canadian volunteer worker] tested positive for inactive TB, meaning that she does not yet have any major symptoms" (TS7, 28/09/99) implies that people with inactive TB experience some minor symptoms of the disease and can expect to develop major symptoms in the future. However, this form of TB is without clinical symptoms of any kind.

Treatment and prevention

Numerous public health organizations around the world, including the Canadian Lung Association, inform the general public that TB is preventable, treatable and curable as part of their campaigns against TB (Canadian Lung Association, 2009). This information educates people that there are effective ways to protect themselves from TB. It also reassures the public that there is an existing treatment which can cure TB. However, only 7% (n=18) of the articles indicated that TB can be prevented, 28% (n=75) indicated that TB can be treated and 6% (n=16) mentioned that TB can be cured. On the contrary, the focus of some articles was directed at the threat of multidrug resistant TB which looms as a threatening pandemic all over the world, although (as indicated in Chapter 3) the rates of this type of TB are still very low in Canada.

6.1.2 Consequences of TB to Canadians

Victim stories

Besides the alleged huge financial cost of immigrant TB to which 15% (n=41) of all articles referred, the most helpful tool to indicate the consequences of immigrant TB to Canadians was the use of stories depicting infected *victims*. Stories of *victims* and *heroes* are very effective narrative elements that newspapers use to stimulate readers' emotions (Seale, 2003). Newspapers described many difficulties that these *victims* went through after being exposed to the disease. Although only nine separate incidents of TB exposure were reported by the newspapers in ten years, a reference to these *victim* stories

in which the spread of infection was identified as the main consequence of immigrant TB in Canada appeared in 37% (n=102) of all articles.

Furthermore, only 3% (n=9) of all articles indicated that the risk of TB transmission from immigrants to Canadians is very low, as was established by several research studies (Fanning, 1995; Hyman, 2001). On the contrary, some articles stated that Canada is no longer safe from TB since "more and more North Americans are being exposed to infection" (MG11, 26/04/00). Despite the fact that in the past decade the only number that has constantly increased was the percentage of affected immigrants, one article asked the question "Who knows how many Canadians have died or been injured as a result [of TB]?" (NP3, 21/08/99). The statistical breakdown of data on the consequences of TB to Canadians as reported by each newspaper is provided in Table 6.2.

Table 6.2: Consequences of immigrant TB by each newspaper

	Newspapers										
Topic	**OC**	**OS**	**GM**	**TS**	**NP**	**MG**	**VS**	**EJ**	**WFP**	**CH**	**Total**
High cost	3	1	12	10	6	3	2	3	0	1	**41 (15%)**
Victim stories	9	10	17	26	11	6	7	6	2	8	**102 (37%)**
Low risk to Canadians	0	1	0	3	0	0	2	1	0	2	**9 (3%)**
Immigrants as victims	1	0	2	2	1	2	0	2	0	0	**10 (4%)**

The *victim* stories included reports and news about Canadian soldiers, civilian volunteers, healthcare workers, border officers and flight attendants, hailed both as innocent and unsuspecting *victims* and as *heroes*, who were exposed to the infection while working with immigrants in refugee camps, hospitals, border offices or on flights. These reports informed readers about the anxiety and stress that these *victims* and *heroes* experienced while waiting for the results of their medical tests and the measures they had to undertake, such as preventative medications and (in some instances forced) work leave. Some filed work compensation claims which were not accepted, as it was difficult to prove that they were exposed to TB at work; others considered suing the government for failing to inform them about the risks of contracting TB while working with refugees. Some expressed the fear of losing their jobs, infecting their families, or being "treated as a leper" (TS10, 01/10/99).

Although the newspapers did not report that any of these *victims* developed active TB over time, one Canadian woman was quoted as calling the situation a "Canadian tragedy" (GM16, 28/09/99). After some of the incidents of possible exposure to TB carried by immigrants were reported, some articles did not even mention whether the exposed Canadians had actually tested positive for inactive TB after this exposure. This was the case of children at one elementary school in Winnipeg and students at a residence of University of Waterloo. Moreover, after extensive coverage of six Kosovo Mercy Flights attendants' exposure to TB, only three articles indicated that, in fact, only three (and not six) attendants were on the flights carrying refugees with active TB.

By contrast, I found that only 4% (n=10) of all articles portrayed the immigrants with active disease as *victims* of TB by providing readers with information about the consequences TB was having on their lives. This is consistent with van Dijk's (1991) finding that minorities are rarely depicted as *victims* by newspapers in the West. Besides the incidents of death, these articles articulated immigrants' difficulties with living in isolation while hospitalized or while living with non-treatable drug resistant TB, with taking a large number of pills when diagnosed with drug resistant TB, with handling other health complications of TB and, as well, with their attempts to keep their diagnosis a secret in order not to lose their job.

Despite describing the difficulties that immigrants with TB faced, some stories sparked negative reactions from readers, as happened in the case of a landed immigrant from the Dominican Republic. His active TB was misdiagnosed for a year, first by an immigration physician who cleared his health record for immigration purposes and then by the family physician who cared for him in Hamilton (ON). As a result, this man exposed hundreds of people to his disease, dozens of whom tested positive for inactive TB. His Canadian wife was also infected and both were hospitalized to get treatment for drug resistant TB. Consequently, the couple, joined by the other Canadians subsequently infected with TB, filed a lawsuit against local public health authorities and the physicians for their failure to recognize the man's illness and thus indirectly causing a large spread of TB infection in Canada.

Some newspapers published readers' responses to this story. One appalled reader advised the immigrant to sue his own country instead of Canada and suggested that a Canadian court should laugh at his case. The letter further stated:

> Let him go home (after having received the high quality medical care that we taxpayers so kindly provide to refugees and anyone else not covered by provincial health care.)… He should be deported as soon as he can be put on a plane. (TS27, 05/01/2001)

This letter is interesting from several aspects. First, it shows that the author lacks any sympathy for the sick immigrant. One wonders if it had been a Canadian-born person whose disease had been misdiagnosed for a year whether the letter writer would have questioned this person's intention to sue his or her physicians. Second, one can see that if a Canadian-born person contracts inactive TB, some fellow Canadians call it a "Canadian tragedy." However, if a Caribbean-born man develops active TB, some fellow Canadians do not see it as a human tragedy that deserves their compassion but instead request the man's deportation. The letter writer's viewpoint is consistent with Henry and Tator's (2002) assertion that a crime (in this case having an infectious disease) committed by white individuals of western origin does not generate any discussion about their deportation, unlike in the case of visible minority immigrants.

In addition, the letter showed the reader's lack of knowledge about the Canadian immigration system. First, the letter writer advised the infected man to sue his home country for not detecting his TB. However, there was no reason to sue his home country as it was not responsible for detecting his TB for immigration purposes. It was solely the responsibility of the employees of CIC. Second, the original article clearly identified the

Caribbean man as a landed immigrant whose X-ray was misread by a Canadian physician working for immigration. In addition, the article stated that the man was employed prior to his illness and he lost his job after he had developed TB. As is true of all employed landed immigrants in Canada, this man was required to pay his share of the taxes which finance Canadian healthcare. However, the reader labeled this man as a refugee who received free care, thanks to taxpayers' money. Unfortunately, the newspaper did not address these points in the reader's letter, a failure which may have further misinformed other readers.

6.1.3 Information about immigrants

The previous sections have demonstrated that newspapers represented immigrants as dangerous sources of TB. However, in many articles, immigrant TB was only a marginal issue which created an opening or a hook for providing other information about immigrants who come to or live in Canada. These articles focused on immigrants' general health status, health-seeking behaviours and other issues unrelated to health, since TB represented only one of the "many" imported immigrant diseases as well as one of the "many" other immigrant issues (MG2, 20/05/99). The statistical data about these topics are provided in Table 6.3.

Table 6.3: Information about immigrants by each newspaper

	Newspapers										
Topics	**OC**	**OS**	**GM**	**TS**	**NP**	**MG**	**VS**	**EJ**	**WFP**	**CH**	**Total**
Health											
Other diseases	1	0	0	1	5	2	0	1	1	0	**11 (4%)**
Good health	1	0	2	2	0	1	1	0	1	1	**9 (3%)**
Health-seeking behaviour											
Health fraud	2	0	0	0	7	4	1	1	0	1	**16 (6%)**
Non-compliance	3	1	6	2	8	4	4	4	0	2	**34 (13%)**
Villain stories	7	2	14	4	12	5	2	2	0	2	**50 (18%)**
Positive messages	2	1	6	6	2	1	3	6	0	0	**27 (10%)**
Positive actions	0	0	1	3	2	1	0	1	1	1	**10 (4%)**
Crisis of the immigration system	4	2	2	0	10	2	2	2	0	3	**27 (10%)**

Health status and health-seeking behaviour

In terms of the health status of immigrants in Canada, out of all articles concerned with this topic (7%, n=20), about 6% (n=11) provided readers with the message that "the tally of immigrant and refugee health problems is long" (MG2, 20/05/99). Newspaper articles blamed immigrants for the following problems:

- bringing in deadly contagious diseases such as TB, AIDS, malaria, hepatitis, syphilis, and leprosy

- arriving in Canada sick and unvaccinated for rubella, hepatitis B, measles, influenza, bacterial pneumonia, and diphtheria
- failing to have their babies screened for thyroid and other problems
- threatening the health of people on streets, subways, streetcars, buses and in shops
- taking hospital beds and nursing home places from Canadians
- using "hideously expensive" dialysis without paying taxes (NP3, 08/21/99)
- burdening the healthcare system

The threat of infectious diseases was the problem most frequently mentioned in the newspapers. Several articles referred to a new computerized system which quantifies the risk of transmission of 47 different infectious diseases. As a result of this risk assessment, Health Canada makes recommendations about the diseases immigrants should be screened for (CICNews, 1997). One Canadian public health official was reported as saying that "if we cut off the infected [immigrants], just about everybody would be excluded. Canada's immigration would be reduced to a trickle" (TS21, 03/12/00). This statement suggests that the vast majority of immigrants harbour infections. Another article, however, specified that sick immigrants come to Canada from places other than USA and Western Europe by stating: "They might be tougher than the rest. But are they sicker, too? For people who immigrate to Canada from outside North America or Western Europe, or come here as refugees, the answer is often yes" (MG3, 20/05/99). This statement in this article typifies the racialization of the sick immigrant discourse since the health problems are associated only with immigrants from outside western geographic space, the space predominantly populated by people of colour.

The claim that immigrants' health is poor or at risk since they arrive in Canada unvaccinated for number of diseases such as rubella, hepatitis B, measles, influenza, bacterial pneumonia and diphtheria is also inaccurate. That claim is, in fact, a curious one because many Canadians are also not vaccinated for hepatitis B, influenza and bacterial pneumonia. Hepatitis B and bacterial pneumonia vaccinations have been introduced to the Canadian public only in recent years, and influenza shots are voluntary. An unpublished study of the risk factors for positive or incomplete infection screening conducted with 2716 diverse women in Toronto in 1999 revealed that only 9.7% of participating foreign-born women showed susceptibility to rubella, hepatitis B and/or syphilis because they were likely not vaccinated or their vaccination was ineffective (Ford-Jones, Kelly, Wilk, Lamba, Bentsi-Enchill, Hannah et al., 1999). This means that 90.3% of examined women were effectively vaccinated for these infectious diseases. These findings contradict the statement that "most immigrant women have not been vaccinated" prior to coming to Canada (MG3, 20/05/99), as some newspaper articles indicated. Reinforcing the incorrect notion that immigrant women fail to protect their health and the health of their children by vaccination and utilization of health services contributes to the public discourse of immigrant women as incompetent mothers (Blackledge, 2000; Villenas, 2001).

Only 3% (n=9) of all articles informed readers that the health status of immigrants arriving in Canada is good, since they undergo medical screening prior to immigration. Only healthy persons are awarded immigration visa. These articles accurately reflect public health research into the *healthy immigrant paradigm* that indicates that

immigrants' health deteriorates only after immigration due to the mental stress experienced, the traditional supports lost and the poor eating and fitness habits developed. Some of these articles referred to the particular experiences of immigrant women. However, these women typically did not speak themselves but their experiences were represented by university researchers and social workers. This approach inappropriately conveys the message that immigrant women are unable to represent, critique or transform their own social realities (Raissiguier, 2003).

Some newspapers acknowledged that some refugees arriving in Canada may be "traumatized after escaping rape and murder" (TS38, 02/05/02) which may negatively impact their health over time. I acknowledge that refugees may carry some burden of illness since their medical screening is required only upon their arrival but they constitute less than 10% of all immigrants annually admitted to Canada (CIC, 2009). In addition, upon their arrival they are treated if necessary. However, many articles did not explain the differences in rules applied to these two different groups of newcomers. These findings are consistent with Randall's (2003) work which found that the media are more likely to present information about the assumed health risks posed by immigrants rather than about the trauma, torture, malnutrition and physical violence they experienced in their home countries.

With respect to health-relevant behaviours, 6% (n=16) of all articles reported that immigrants commit health fraud and 13% (n=34) reported that immigrants do not comply with medical surveillance and therapy. The messages blamed immigrants for the following matters:

- giving false medical test results obtainable by bribing or threatening doctors, or by buying clean health records on the black market
- refusing therapy for TB
- failing to visit doctors in Canada
- failing to be screened for cervix and breast cancer
- failing to attend prenatal classes and thereby putting their fetuses at risk
- failing to be screened for chronic cardiovascular problems
- failing to understand the system due to cultural and language barriers
- abusing health benefits

Several articles mentioned the problem of immigrants and foreign doctors faking medical records for the purpose of obtaining an immigration visa to Canada. This problem would presumably be solved if would-be immigrants were examined by Canadian physicians using Canadian equipment. One article recommended that any Canadian doctor caring for immigrants should assume "that nothing has been undertaken" (MG3, 20/05/99) with respect to the medical examination of his/her clients abroad and therefore should evaluate their status accordingly. These are good examples of *other*ing discourse that employs polarizing opposites: deceiving and untrustworthy foreigners versus honest and trustworthy Canadians. Maybe not surprisingly, CIC introduced a more thorough monitoring of appointed foreign physicians abroad who now work jointly for the immigration services of Canada, the USA and Australia. If convicted of any fraud, they lose their mandate to work for all three countries (Health Management Branch, 2009).

The problem of underutilization of Canadian health services by immigrants is indeed a recognized public health issue, as it is known that immigrants face many systemic organizational and socio-economic barriers which prevent them from utilizing services (Hyman, 2007). However, the articles did not refer to these structural barriers, with the exception of some that mentioned factors such as lack of information and linguistic differences. For instance, the lack of contextualization of health choices of immigrant women who may be not able to attend prenatal classes due to a lack of childcare, transportation or culturally unsuitable setting (Reitmanova & Gustafson, 2008) reinforces racialization of women's health behaviours and contributes to the imagining of immigrant women as unfit and irresponsible mothers.

In the case of a Peruvian refugee who was threatened with jail for non-compliance with his drug resistant TB therapy, his non-compliance was also racialized. It was blamed largely on his lifestyle as an irresponsible drunk who did not answer the door to his therapy-supervising nurse because "he gets drunk on weekends and feels hung over" (MG17, 01/12/00). In addition, the article stated that his regimen was not followed because he forgot, he was busy or the pills made him nauseous. Only a few articles noted that the therapy he failed to comply with actually consisted of 24 pills to be ingested on a daily basis for a period of at least eight months. In addition, none of the serious side effects of his therapy were mentioned. One article did indicate that the occurrence of side effects is one of the reasons why immigrants refuse therapy, but it described these side effects as skin rash and upset stomach. Only a few articles mentioned that the Peruvian

refugee later agreed to follow the prescribed therapy and only one article mentioned that he completed his treatment and was proclaimed non-infectious.

News coverage of the Vancouver physician who was taking preventative medication after contracting inactive TB from a Burmese refugee in the hospital was very different. The newspapers reported that the medication (INH - Isoniazid) "can kill her liver" (NP2, 14/08/99) and indicated that "she will suffer permanent liver damage" (OC4, 31/08/99). This means that immigrants undergoing a similar or even more difficult therapy regimen were not characterized in a similarly sympathetic way.

This differing treatment by the media is consistent with van Dijk's (1991, p.64) finding that when minorities such as blacks "are accused or jailed they are described as 'blacks,' whereas when they are cleared of an accusation, they suddenly lose colour." In a similar vein, when the refugee complied with and completed his long and difficult therapy, his story disappeared from the newspapers' radar. In general, the amount of negative reporting about this story could hardly be offset by the brief sentence that appeared in one article which stated that "most refugees comply" with treatment in Canada (MG16, 01/12/00).

Finally, I should point out that it seems a curious contradiction to state that, on the one hand, immigrants avoid seeking medical help, refuse therapy and escape from medical surveillance while, on the other hand, stating that immigrants pose a burden to the Canadian healthcare system by draining Canada's precious resources (e.g., MG3, 20/05/99).

Villain stories

The employment of *villain* stories is another effective narrative element used by newspapers for the emotional stimulation of readers (Seale, 2003). Portraying immigrants as disease carriers and health fraudsters furnishes only two pieces of the bigger picture of 'the immigrant as *villain*' that newspapers introduce to readers. Indeed, 18% (n=50) of the articles referred to immigrants and refugees in Canada in pejorative terms. Several editorials labeled immigrants as "trash" (NP1, 03/04/99) and "deadbeats" (NP11, 30/06/01) that Ottawa let in. In one letter to the editors, refugees were accused of being bogus "opportunists who are shopping countries" by making up sad stories for which Canadians have to pay (MG6, 13/09/99) or who "'baby in' during the long waiting to claim entitlement as a parent of a Canadian child on humanitarian grounds" (OS18, 03/01/02).

Both immigrants and refugees were blamed for committing serious crimes, stealing jobs from Canadian youth, burdening the education and housing systems, abusing the welfare system, belonging to terrorist groups, and smuggling drugs. For instance, the wave of refugees who were labeled Chinese boatpeople were represented as follows: "…virtually all of them are wanted crooks or indentured to crooks, or are smugglers. That's why these arrivals should have been jailed … Instead Ottawa used our tax dollars to give them room service [a place in a detention centre] …" (MG6, 13/09/99). These findings conform to those of other scholars who have discovered that immigrant health issues operate as an entry point to the larger picture that constructs immigrants as, for instance, criminals, prostitutes and hindrances to economic

development (Greenberg, 2000; Hier & Greenberg, 2002) as well as threats to national security (Karim, 2000).

Since all immigrants associated with these negative behaviours were people of colour, labeled as bogus Tibetan refugees, Chinese triads, Vietnamese gangs, drug smugglers from Honduras, Somali warlords, dangerous francophone Muslims and Algerian terrorists, the racialization of the immigrant threat discourse was reinforced once again. This negative reporting on visible minority immigrants and their affairs is consistent with the findings of van Dijk (1991, p.21) that these groups of people are consistently seen by the media as "a problem or a threat, and … portrayed preferably in association with crime, violence, conflict, unacceptable cultural differences, or other forms of deviance."

Only 10% (n=27) of all articles mentioned something positive about immigrants. These stories included messages about immigrants' good health status upon arrival, and the fact that getting infected with TB is a risk for anyone who works with people rather than being in contact with immigrants. One article said that "Canada benefits economically by taking some of the best, brightest and healthiest people from different parts of the world" (VS11, 05/12/00). Another article informed readers that most of the recent immigrants are highly skilled and educated. An additional article noted an example of a Tibetan community in Toronto that offered help to fellow refugees upon their arrival. Lastly, as indicated earlier in this chapter, some articles stated that "calling TB a disease

of immigrants is not a fair characterization" (GM43, 18/05/02) and explained the links between immigrants' health and the socioeconomic circumstances of their lives.[10]

Van Dijk (1991, p.61) further indicated that the media often portray minorities as passive recipients of positive actions, meaning that "something good is done for them" for which they should be thankful. A small percentage, 4% (n=10) of all articles, employed this element. Most of these articles featured stories from the refugee camps in which "weary" Kosovars repeatedly expressed their gratitude to their "humble" Canadian saviours for opening their hearts to them (MG1, 05/05/99). The articles described how volunteers distributed comfort kits for refugees and toys for children in order to "provide the human touch to make their welcome to Canada a little warmer and softer" (MG1, 05/05/99). They also featured a story of then Prime Minister Chretien who played basketball with some refugees during his visit. These articles did not provide, however, any information on the hardship and difficulties that many refugees face in Canada after leaving the refugee camps. Another story that ran in a newspaper was a report on the construction of new health centres for immigrants that would provide for their diverse cultural and social needs. Still other articles mentioned the excellent high quality medical care that immigrants receive in Canada. These reports reinforced the representation of immigrants as passive beneficiaries of positive actions.

[10] I ranked these stories as positive since they did not attribute TB to immigrants' country of origin but to their poverty in their new country.

Crisis of the immigration system

Another important topic presented by newspapers was the crisis of the Canadian immigration system. This topic was employed by 10% (n=27) of all articles. The focus of these articles was the Canadian border which was supposed to protect the nation from TB (and other diseases). As one article noted, "As long as tuberculosis is raging outside our borders, we'll always have an issue with it here (TS49, 30/09/06)." Therefore, some Canadians asked for "tighter border controls [to] protect [them] from this almost untreatable death sentence" (EJ21, 24/03/07). However, many articles pessimistically admitted that the Canadian borders can no longer provide protection since "there is no magic wall" that Canadians can erect against germs which do not recognize borders (EJ8, 07/12/00). Another article put it this way: "Whether we travel abroad, accept refugees and immigrants, import raspberries, or allow birds and mosquitoes to cross our borders, we are no longer immune...(TS14, 10/10/1999)." One article indicated, "There isn't a barrier high enough to stop it [TB]" (TS 21, 03/12/00).

However, the problem of TB lurking just beyond the Canadian borders was not the only reason why the reliability of Canada's immigration system was questioned. Since Canada allegedly lets in too many undesirable immigrants, the immigration system was regarded by some articles as "a joke" (NP1, 03/04/99) and as a system that is "cash-poor and weakly managed" (OC8, 12/04/00). As a result of extremely liberal and ineffective policies which offer better protection to the dogs than to the people (NP2, 14/08/99), the safety and security of Canadians was thought to be endangered. According to some authors, Canada became the "laughing stock of the developed world" and was a

"land of suckers" for making "sick pay forever" possible because of its lax immigration system (MG6, 13/09/99).

While reporting on the crisis of the immigration system, some newspapers employed a twitch – an element to disrupt readers' expectations. In many articles, newspapers employed an old template in which immigrants played the role of *villains*. However, in stories of the crisis in Canada's immigration system, the role of *villains* was assumed by the Canadian politicians who turned this system into "a vote-importing and a vote-buying device" (OC27, 23/08/05) and the immigration lawyers who allegedly corrupted the system to pay for their luxury houses and their kids' orthodontics. One article suggested that the government should stop pretending success in guarding Canadians and eliminate the borders since they are unable to protect Canadians from "foreign invasion" (NP2, 14/08/99).

These numerous examples demonstrate how health-related immigrant issues can be (re)constructed as a crisis in the immigration system that allows immigrants, represented as sick and ill-mannered people, to penetrate a nation of presumably healthy, law-abiding and innocent citizens. The press's negative images have the powerful potential to mobilize the nation to request protection (once again reiterated by the media) from such evils by securing the national borders which symbolize "order, control and cleanliness" (Murdocca, 2003, p.26). In Bashford's words (1998), "the language of health and disease has often been implicated in the creation of boundaries, associating the self with cleanliness and purity, and the other with dirtiness and unhealthiness" (p.390). One

article, citing a former CSIS[11] agent, proposed that Canada should build internment camps for immigrants and refugees similar to those in Australia where these migrants are kept until cleared. In addition, it continued, immigrants and refugees that authorities do not know enough about should wear tracking bracelets like those worn by criminals until CSIS clears them. It was noted that for refugees who face certain torture or mistreatment in their homelands, such bracelets would become "a healthy compromise" (OC27, 23/08/05).

6.1.4 Solutions for immigrant TB in Canada

Some solutions for immigrant TB in Canada were directly articulated by the newspapers while others were implied. Since the TB of immigrants was constructed as imported disease, as indicated in the paragraphs addressing epidemiologic trends, the newspapers suggested that Canada must act: "Do more to stem a growing flood of cases overseas or grapple with the inevitable import and spread of the illness here" (TS47 & MG29, 25/03/06). The information about the proposed solutions by each newspaper is organized in Table 6.4.

Since the majority of articles framed the issue of immigrant TB in Canada as an imported problem, not surprisingly 45% (n=122) of all articles referred to screening and surveillance as the main solution, while only 11% (n=29) articulated the need for addressing the social determinants of health for people affected with TB. This finding is consistent with the studies conducted by Bell et al. (2006) and Lawrence et al. (2008)

[11] CSIS refers to the Canadian Security Intelligence Service. The role of this agency is to protect Canadian national security interests.

which found that press coverage of the immigrant TB problem in the UK and New Zealand did not offer any substantial analysis of the social and economic context responsible for the higher burden of immigrant TB in those two countries.

Table 6.4: Solutions for immigrant TB in Canada by each newspaper

	Newspapers										
Topic	**OC**	**OS**	**GM**	**TS**	**NP**	**MG**	**VS**	**EJ**	**WFP**	**CH**	**Total**
Solutions											
Screening & surveillance	14	6	26	25	17	6	13	7	2	6	**122 (45%)**
Biomedical model	4	1	1	3	2	2	3	6	1	1	**24 (9%)**
Social determinants	1	0	10	5	0	2	2	3	6	0	**29 (11%)**
Social determinants & immigrants	0	0	4	1	0	0	0	2	1	0	**8 (3%)**

The improvements in Canada's "poor," "sloppy," and "fragmented" screening and surveillance system, according to the newspapers, must start overseas with increased funding for more TB control programs. Canada must stop "fraudulent" and "diseased" immigrants from cheating the screening system, and as well, consider screening of all immigrants for latent TB. Physicians both at home and abroad must get better training in interpreting the X-rays used to diagnose TB. Regarding Canada's policy of allowing refugees with active TB to seek asylum in the country, some articles suggested that "a high-minded refugee policy may be also an irresponsible public-health policy" (GM9,

09/09/99). Supporters of this line of thought expressed in their letters that "turning back refugees with dread communicable diseases rings harshly in the moral mind; unfortunately, the alternative is morally worse" (GM9, 09/09/99) and also "Medical status is not currently a consideration in deciding refugee status, but perhaps it should be" (GM13, 22/09/99).

A number of articles suggested that in order to prevent infection from being spread in Canada, immigrants with latent TB must be monitored more effectively by improving communication between immigration and health authorities and by developing specific centralized TB control programs for which establishment provinces should receive more money from Ottawa. It was suggested that immigrants also needed to be better educated about the benefits of disease surveillance and that those who cannot speak English or French should be provided with translators. A database of people in compliance with medical surveillance should be developed and those who do not comply should be punished by being denied a driving license or even Canadian citizenship. One article proposed establishing a national genotypical database of all persons diagnosed with latent TB in order to track its spread in the country.

In addition, 9% (n=24) of all articles stressed the importance of antibiotics and vaccines, the two factors credited with the success that the western world has achieved over TB in the past century. Messages such as "TB was nothing but eliminated from Europe and North America" (MG 26, 28/05/03) thanks to modern antibiotics and

vaccination and "DOTS[12] holds the keys to wipe out TB" (WFP1, 24/03/99) were relatively easy to find in the selected articles, while the massive efforts needed to improve people's socioeconomic conditions, nutrition and living standards and to provide extensive public health projects such as large-scale sanitation, individual hygiene education and milk pasteurization remained overlooked. This biomedical discourse of TB—suggesting that TB can be effectively treated just by administrating chemicals to an infected body—was adopted in the West with the arrival of antibiotics and advanced technology in the middle of the twentieth century (Feldberg, 1995; McCuaig, 1999). Since that time the role of social factors in the conceptualizing of TB has been de-emphasized. Not surprisingly only 11% (n=29) of all articles delivered the type of message that suggested that TB "cannot be brought under control without tackling the poor living conditions that foster its spread" (WFP11, 07/02/04). These articles stated that "it is vitally important for governments to provide more affordable housing, ease crowding in shelters and improve ventilation" (TS42, 29/11/04) because, according to these articles, "TB had been pretty much eliminated in urban Canada by public health and social housing programs, only to be brought back by cutbacks focused on the bottom line" (GM12, 16/09/00).

About 3% (n=8) of the articles made an explicit link between the need to address the socio-economic context of immigrants' lives together with their health and TB problems. As one article stated, "Growing economic disparity and social polarization threatens to erode the progress we have made" and [if this disparity continues], "we are

[12] DOTS refers to Directly Observed Therapy. Refer to Chapter 3 for a more detailed explanation.

putting the whole population at risk, including low-income families, children, new immigrants, refugees and the homeless" (GM36, 22/01/01). This type of article noted that visible minority immigrants in Toronto experience huge inequalities in income, employment, education, access to services and poverty rates. These inequalities have led to "the emergence of concentrated pockets of an immigrant underclass" and "the long-term ghettoization of immigrants in a number of Toronto's inner suburbs and downtown neighbourhoods" (TS35, 30/03/02). Numerous studies support the assertion that visible minority immigrants tend to be at the bottom of the Canadian socio-economic ladder and are more likely subject to health inequalities (Fleury, 2007; Hay et al., 2006; Kazemipur & Halli, 1997; Lee, 2000; National Council on Welfare Reports, 2006; Ornstein, 2006).

6.2 Quotations and sources

The examination of quotations and sources of communicated information is a very important element complementing discourse analysis. Quotations not only enrich the news but they also increase the credibility of news accounts. More importantly, they "allow the insertions of subjective interpretations, explanations, or opinions about current events, without breaking the ideological rule that requires separation of facts from opinions" (van Dijk, 1991, p.152). As indicated in Chapter 1, non-whites have considerably lower access to resources such as power, money, status, and education than many white people do. These resources allow some white people to produce knowledge through public discourse and thereby define the representation of those who do not have similar access (van Dijk, 2001). This public discourse is difficult to challenge since it is produced by scholars, experts, professionals, or reliable media which are seen as

authoritative, trustworthy, or credible sources. By contrast, visible minorities "are seldom heard as having an opinion about majority actions and policies" (van Dijk, 1991, p.154) and often speak only through left-wing politicians, lawyers or action groups. When the opinions of minorities are published, they are marked by quotation marks or words such as "accuse" or "allege" followed by a source which softens or denies these "accusations" by minorities.

In this section, I examine the chosen sources and identify how often and about what the quoted actors expressed their opinions, so as to determine if immigrants were given the opportunity to speak about and define their issues in the Canadian press. The statistical data on quotations and sources provided in Table 6.5 show that while 69% (n=187) of all articles quoted members of the dominant groups or used them as sources of information, only 4% (n=11) cited immigrants. While it is possible that some of the authors were visible minority immigrants their voice was not identified as being that of an immigrant. This uneven distribution of information sources is consistent with findings reported elsewhere about the underrepresentation of immigrant voices in the European and the North American press (Eichelberger, 2007; Henry & Tator, 2002; ter Wal, 2002; van Dijk, 1991; Washer, 2004).

Table 6.5: Quotations and sources by each newspaper

Newspapers											
Quotations & sources	**OC**	**OS**	**GM**	**TS**	**NP**	**MG**	**VS**	**EJ**	**WFP**	**CH**	**Total**
Dominant groups	21	13	30	35	20	21	13	13	9	12	187 (69%)
Immigrants	1	0	2	2	2	1	0	3	0	0	11 (4%)

The cited sources that I classified as dominant group sources included public health officials, physicians, university professors, immigration officials, politicians (including the Prime Minister, Cabinet Ministers and Members of Parliament), lawyers, social and community workers, the RCMP, CSIS and FBI agents, school officials, nuns, and radio broadcasters. Most often, they were cited directly or indirectly after being interviewed, or their opinions were collected through research, studies, releases and conferences. Their opinions were sought to explain the immigrant TB problem in Canada, its consequences and potential solutions as well as related problems with the Canadian immigration system and associated solutions.

In other articles, immigrants spoke through lawyers, social and community workers, university professors, and politicians from the New Democratic Party (NDP) and the Liberal Party who were championing their causes. For instance, a former NDP leader, Alexa McDonough, was quoted saying that "she [was] sickened and horrified by the way the federal government [was] treating the recently arrived Chinese children, parading them before cameras in handcuffs, wearing oversized overalls" (OC3,

21/08/99). She expressed that such a treatment was "exploiting peoples' insecurities and fears, instead of appealing to peoples' sense of humanity" (OC3, 21/08/99).

In contrast, immigrants were quoted minimally. One exception was the story told by an immigrant woman who was denied health insurance because she had postponed, upon the advice of an immigration physician, her chest X-ray exam for TB because she was pregnant (OC1, 16/03/99). After her case was championed by liberal MPs, she was granted an exemption and received health insurance. One can only speculate whether or not this woman's social position as a white Dutch immigrant working as an international affairs consultant and married to a Canadian-born man made a difference in the newspaper's decision to give space to this story.

In another story, newspapers quoted the father of an immigrant family from the Philippines who claimed that his wife, a nurse, died as a result of the slow medical response to complications of her TB (TS1, 23/03/99). Still another article cited an immigrant woman from India who recounted the post-migration difficulties she was experiencing since moving to Canada (EJ19, 28/10/04).

These findings indicate that newspapers used members of the dominant group as their sources much more frequently (precisely seventeen times more) than they used immigrants. Therefore the problem of immigrant TB was defined mainly in terms framed by dominant actors and interpreted by the press. While some dominant actors representing immigrants' interests used their power toward positive depiction of immigrants, the overall representation was negative. The frames in which the majority of actors defined the problem of immigrant TB reinforced prevalent public health discourses

about TB as an imported problem associated with immigrants' foreign origin while important links between poverty and immigrant health remained greatly understated. Newspapers in this way contributed to the medicalization and racialization of immigrant post-migration experience.

The following chapter will summarize my findings and discuss the relationship between the identified press discourses and prevalent public health discourses of immigrant TB as they relate to a larger historic, social and political context of immigration in Canada. I will also provide conclusions about the role that the identified discourses play in maintaining institutional racism in Canadian healthcare. Finally, I will provide several recommendations directed at public health policy makers, service providers and researchers, and also media workers.

Chapter 7

Conclusions, recommendations and future research

> *Nothing handed down from the past could keep race alive if we did not constantly reinvent and re-ritualise it to fit our own terrain. If race lives on today, it can do only because we continue to create and re-create it in our social life, continue to verify it, and thus continue to need a social vocabulary that will allow us to make sense, not of what our ancestors did then, but of what we choose to do now.*
>
> Fields, 1990, p.118

The previous chapter identified the discourses which underpin the coverage of immigrant TB in the Canadian press in the past decade. In this concluding chapter, I summarize my findings and discuss the relationship between the identified press discourses and public health discourses of immigrant TB. Specifically, I draw conclusions about how oppression and institutional racism in the Canadian health care system are (re)produced through public discourse and how the existing power relationships shape the (re)production of the identified discourses. Drawing on these conclusions, I make several recommendations directed at public health policy makers, service providers and researchers, and also media workers in Canada. Finally, several directions for future research are outlined.

7.1 Summary of study findings

There were 273 articles published about immigrant TB during the ten-year period between January 1, 1999 and December 31, 2008. The highest number of relevant articles appeared in the newspapers published in Ottawa, Toronto and Montreal, mapping TB stories which mainly originated in urban areas of ON, QC, BC and AB. TB coverage

from the places where prevalence of immigrant TB is very low was very limited. The information that TB is low in places with good socio-economic standards of immigrants could contribute to a better understanding of immigrant TB etiology. However, this information was absent in the news reports. There were a total of 121 different authors of newspaper articles including editorials and letters to the editor. The fact that such a large number and variety of authors contributed to the (re)production of the similar discourses supports van Dijk's (1999) ideas that mainstream discourse producers advance similar ideological positions. The frequency of articles about immigrant TB published during the study frame declined from 85 to 3 despite the fact that the proportion of immigrant TB cases in Canada remained very high in the same time period. It is possible that news about the immigrant TB problem were less visible in Canadian newspapers because the old threat of immigrant TB was replaced by other perceived threats such as terrorism, SARS and cultural differences. In general, the newspapers informed readers about the problem of immigrant TB mainly through the sensational (but rare) incidents of disease exposure to native born Canadians and through official reports criticizing the loopholes in the TB public health monitoring system.

I found that the Canadian press utilized discursive strategies similar to those employed by the western press in USA and 16 European countries (Eichelberger, 2007; Greenberg, 2000; Grzymala-Kazlowska, 2009; Henry & Tator, 2002; Hier & Greenberg, 2002; Leung & Guan, 2004; Murdocca, 2003; ter Wal, 2002; van Dijk, 2001, 1999, 1996, 1991; Washer, 2004). I identified the following four discourses in the coverage of immigrant TB in the selected Canadian press during the past decade:

1. the discourse of an immigrant health threat
2. the discourse of immigrants as a racialized *dangerous inferior Other*
3. the discourse of a crisis in border protection
4. the discourse of the medicalization and racialization of the immigrant post-migration experience

Some of these discourses were conveyed through the use of othering (*us* and *them*) strategies when representing immigrants, which could, according to Seale (2003), boost readers' fear and anxiety about immigrants and their presumed problems. These strategies included: the use of paired polar oppositions (Canadians as *heroes* and *victims* versus immigrants as *villains*); media templates for developing desired ready-made stereotypes, judgments and interpretations; and twitches that disrupted readers' expectations (politicians and lawyers as *villains*). This finding is in agreement with Seale's (2003) work on media representation described in Chapter 4. I discuss each discourse in turn.

Discourse of immigrant health threat

In accord with two other international studies which looked at press coverage of immigrant TB in the UK (Bell et al., 2006) and in New Zealand (Lawrence et al., 2008), I found that the Canadian press depicted TB as a feared foreign disease imported to the country by immigrants. The news reports lacked important information about the magnitude and scope of TB in Canada or about its natural history and preventability. Instead, the reports often informed readers about innocent unsuspecting Canadians who

had contracted inactive TB during their contacts with immigrants. Although only nine separate incidents of exposure to TB were reported by the newspapers in ten years, a reference to these *victim stories* appeared in 37% of all articles. Immigrants as *victims* of TB were portrayed by only 4% of all articles, which is consistent with van Dijk's (1999) finding that minorities are rarely portrayed sympathetically in the press. In addition, this unbalanced reporting of TB transmission contradicts the findings of scientific studies that report limited risk of transmission of TB from immigrants to the Canadian-born population (Fanning, 1995; Hyman, 2001; Menzies et al., 1997). The discourse of the immigrant TB threat was further reinforced by the newspapers' failure to report the post-migration latency period after which immigrants developed active TB in Canada. Several studies found that this latency period ranged from 2 to 14 years (Cowie & Sharpe, 1998; Kerbel, 1997; Public Health Research and Evaluation Division, 2000) but only 3% of all articles reported this information.

Besides being represented as a TB threat, immigrants were depicted by the press as importers of many other health problems. These depictions included being blamed for bringing in deadly contagious diseases such as HIV/AIDS, malaria, hepatitis, syphilis, and leprosy; arriving in Canada unvaccinated and unscreened; and burdening the capacity and performance of the Canadian healthcare system. Immigrants were also associated in the press with health fraud, non-compliance with medical surveillance and therapy, and underutilization of health services. Very few newspapers, however, reported on the larger systemic organizational and socio-economic factors that underlay immigrants' health-seeking behaviour patterns. It must be noted that all immigrants who were depicted in

this negative way were believed to be coming from low-income world regions, a fact that reinforced the racialization of the immigrant health threat discourse. This is consistent with the findings of Eichelberger's (2007), Leung & Guan's (2004) and Murdocca's (2003) studies, which pointed out the problems of racializing infectious diseases such as SARS and Ebola fever in the USA and Canada.

Discourse of immigrants as the racialized dangerous inferior *Other*

In many articles, the threat of immigrant TB was only a marginal issue which created an opening or a hook for providing other information about immigrants in Canada. My analysis, in accord with van Dijk's (1999, 1991) work, found that immigrants were associated mainly with negative actions while at the same time considered to be passive beneficiaries of positive actions when something good was done for them. They were blamed for committing serious crimes, stealing jobs from Canadian youth, burdening the education and housing systems, abusing the welfare system, belonging to terrorist groups, and smuggling drugs. The credibility of refugee claimants was often doubted. Additionally, since all the immigrants associated with these negative behaviours were reported to be people of colour, the newspapers once again reinforced the racialization of the immigrant threat discourse. In addition, immigrant women were often invisible in these stories. If mentioned, they were associated with risky health choices and behaviours which tend to reinforce the belief that some immigrant women are incompetent mothers (Blackledge, 2000; Villenas, 2001).

These findings conform also to those of other scholars who have found that the Canadian media often depicted immigrants as criminals, prostitutes, hindrances to

economic development (Greenberg, 2000; Hier & Greenberg, 2002) and threats to national security (Karim, 2000; Henry & Tator, 2002). This racializing discourse is problematic as it reinforces prejudice and discrimination of some groups of immigrants who consequently experience less access to resources such as rights, employment, housing, education, healthcare, safety, welfare, legal defence, information, respect, social status, and a clean environment (Gallagher, 2004; Jones, 2000).

Discourse of crisis in border protection

My study found that 10% of all the analyzed articles framed the problems of immigrants (including immigrant TB) as a crisis of the Canadian immigration system. The ultimate focus of the majority of articles was Canada's failure to safeguard its borders and protect the nation from TB and other immigrant menaces such as crime, fraud and terrorism. Numerous commentaries indicated that the solution to presumed immigrant threats was primarily seen to be tighter control of the Canadian border. These findings are consistent with those of Greenberg (2000), Hier & Greenberg (2002), Karim (2000) and Murdocca (2003). Similar calls from politicians and the public for the government to tighten border control because of a perceived immigrant TB problem were recently made in the UK (Bell et al., 2006; Hargreaves, Carballo & Friedland, 2009; Welshman & Bashford, 2006) and New Zealand (Lawrence et al., 2008). The particular discourse of tightening borders is highly problematic as it does not address the underlying causes of TB occurrence among immigrants. Since TB reactivates several years after immigration in the population of socio-economically disadvantaged immigrants, tightening borders represents a very ineffective tool in immigrant TB control.

Discourse of medicalization and racialization of immigrant post-migration experience

Only 8% of all articles identified poverty-ridden living conditions as a risk factor for developing active TB among the immigrant population of Canada and only 3% of the articles made an explicit link between the need to address the socioeconomic context of immigrant lives with their health in general and with TB in particular. Since the majority of articles framed the issue of immigrant TB in Canada as an imported problem, not surprisingly 45% of all articles referred to screening and surveillance as the main solution for this problem, while only 11% articulated the need to address the social determinants of the health of people affected with TB. These findings are consistent with the study conducted by Hayes, Ross, Gasher, Gutstein, Dunn and Hackett (2007) which indicated that Canadian newspaper health stories rarely report on socio-economic influences underlying population health status. Also studies that examined the press coverage of immigrant TB in the UK and New Zealand reported a similar problem: newspapers ignored the commonalities in the distribution and experience of TB among immigrants and other marginalized groups in both societies and did not provide any analysis of the social and economic context responsible for the higher burden of TB in these populations (Bell et al., 2006; Lawrence et al., 2008). Newspapers in those countries also failed to report on the existing heterogeneity of the immigrant experience. Because of the tendency to medicalize and homogenize the immigrant post-migration experience, the problem of TB was often attributed to immigrants' origin, race or nationality rather than to a lack of social and economic policies to address existing systemic inequalities shaping

immigrants' health status. In addition, this discourse did not consider the role of gender in producing health inequalities among some immigrants and thus reinforces the invisibility of the experience of those groups of immigrant women who carry higher TB burden than their male counterparts. The medicalizing and homogenizing discourse is problematic because it reduces the complexity of the TB patient's experience to a physiological stereotype which leaves minimal space for social, cultural or political explanations of human experience (Morgan, 1998). As a result, this discourse reinforces the notion that the problem of immigrant TB in Canada can be solved by biomedical answers such as screening, surveillance and drug therapy rather than larger socio-economic and political interventions.

7.2 Conclusions about the press representation of immigrant TB

Since 1987 the highest proportion of TB in Canada is associated with the immigrant population (PHAC, 2008a). Immigrant cases of active TB represent about 66% of all cases diagnosed annually in the past ten years (PHAC, 2008a). This high burden is typically linked in the public health literature to country of birth, low education, and various barriers to primary care (PHAC, 2008a; Wobeser el al., 2000). The role of poverty and material deprivation in the etiology of immigrant TB is understated despite the research evidence linking poverty and TB (Carballo et al, 1998; Kent et al., 2003; King, 2003; WHO, 2005). Some immigrant groups in Canada experience profound social inequalities with respect to employment, income, housing, nutrition, social status and access to services (Fleury, 2007; Hay et al., 2006; Lee, 2000). These social inequalities

increase the risk of TB reactivation in racialized groups such as immigrants. The embodied inequalities such as a higher TB burden in these populations then perpetuate our racialized view of their biology. Racializing TB and its carriers highlights the dual focus of TB control: guarding the health of the nation at the borders by excluding the sick and by monitoring of those immigrants already in the country. More importantly, this racializing focus makes current TB control an example of institutional racism. Public health policies that neglect the social determinants of immigrant TB perpetuate the higher rates of TB distribution found in the immigrant population.

The racializing character of these policies is grounded in the discourse about "inherently inferior and diseased" immigrants' bodies, which was central to the development of TB control in Canada at the beginning of twentieth century (McCuaig, 1999; McLaren, 1990). The continuous (re)production of the racializing discourse about immigrant TB through various means of social production (including media) can be explained through the cycle of oppression which I adapted from Etowa and McGibbon (2008, p.25) (see Figure 7.1).

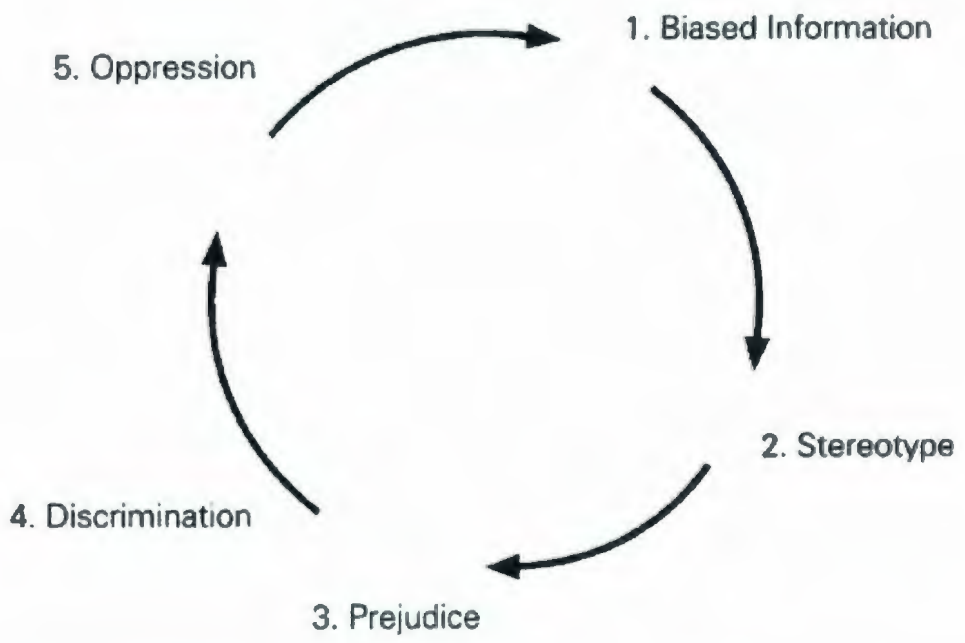

Figure 7.1: The cycle of oppression (Etowa & McGibbons, 2003, p.25)

The practical application of this cycle to my work explains how the provision of inaccurate and unfair information about immigrant TB at the end of nineteenth century reinforced the system of oppression in the form of racializing policies that are unresponsive to immigrants' health needs. Briefly reiterated, the ideology based on a hierarchy of races in which whites were regarded as superior was the reason that *the Other* (a visible minority immigrant) usually acquired a wide range of negative associations, connotations and meanings in public health discourse (Miles & Brown, 2003; Said, 2003). These "over-simplified, standardized, …exaggerated and distorted images (or caricatures)" emphasized or inflated the physique, culture and behaviours of those immigrant groups who were presumed to be different from the dominant group

(Hughes & Kallen, 1974, p.91). Some immigrant groups became known as inherently inferior, degenerate, and uncivilized disease-breeders and TB became associated with their presumably inferior genes and bodies (Devereux, 2005; McCuaig, 1999; McLaren, 1990).

These discourses about immigrant health were effectively channeled by notable public health reformers, prominent physicians, social workers, politicians and journalists through media and other means of social representation into public realm (McLaren, 1990). As Hall (2007) says discourse producers "have the power to make [the produced knowledge] true – i.e. to enforce its validity, its scientific status" (p.57). The presumed authority, trustworthiness and credibility of the media facilitated the general acceptance of these dominant beliefs, knowledge and opinions about the reasons underlying immigrant TB. The erroneous beliefs then led to the formation of prejudice and discrimination of some immigrants with TB by creating policies concerned with screening and surveillance. These policies have not been changed for a century. All prospective immigrants are subject to medical assessment. Those with active TB are barred from entering the country. Those with latent TB are preventively treated and monitored while the link between TB and the post-migration experience of poverty remains overlooked.[13] Policies continue to contribute to racializing TB and its carriers because of the misconception that the cause of immigrant TB lies either in immigrants'

[13] I acknowledge that the biomedical approach to TB control that neglects the poverty applies also to the Canadian-born population (including Aboriginals). However, the TB burden of immigrants is six-times greater than that born by the Canadian-born population and three-times more than that born by the Aboriginal population (PHAC, 2008). For this reason, I am more critical and concerned about the approach to immigrant TB.

presumably inferior genes or in their foreign origin (i.e. their race, ethnicity, or nationality). In addition, policies do not reflect the role of gender in the risk of developing active TB and homogenize the experience of poverty and discrimination of immigrant men and women.

This study of immigrant TB media coverage illustrates that the racializing discourse of immigrant health that exists in public health literature is reflected and (re)produced by the contemporary Canadian press. My findings show that the coverage of immigrant TB in the selected press was inaccurate and unbalanced. The press (re)produced the prevalent racialized public health discourse of immigrant TB as an imported problem disconnected from immigrants' post-migration experiences of poverty and other social inequalities. News reports which do not reflect the complex picture of immigrants' post-migration experiences obscure the complexity of TB reactivation experience. News reports also tend to homogenize immigrants as one entity with a similar identity and experience, since the risk of TB is linked to being an Asian or an African rather than to being a poor, malnourished and stressed immigrant. The invisibility of post-migration experience of immigrant women is also apparent in the press discourse. The Canadian press dedicated very limited space to describing their experiences and possible links between these experiences and the burden of TB in this population of women. This inattention to gender and the diversity among ethnic groups has an homogenizing effect in the construction of the immigrant in the public imagination. This fact along with discriminatory health policy and practices may reinforce the racialized view of TB among immigrants. Similarly, overlooking the shared experience of some

immigrants and other marginalized minorities in Canada (such as Aboriginal populations that also experience high rates of TB) also reinforces the very same notion of racializing TB.

By (re)producing racializing discourses of immigrant TB, the contemporary Canadian press validates and reinforces the merit of policies concerned with the screening and surveillance of immigrants. Policies with an institutionalized focus on race, ethnicity, country of birth, and nationality which are unresponsive to socio-economic and political determinants of immigrant TB in Canada are just one example of institutionally-mediated racism. By validating and reinforcing this type of policies the press contributes to the preservation of institutional racism in the Canadian healthcare system.

I do not suggest that there is a causal link between the negative media representation of immigrants and racist policies. Rather, the two are mutually reinforcing because the common ideologies and discourses "are jointly produced, each acting within its own sphere of influence and control, but each also dependent on the other," at least in part, for their discursive authority (van Dijk, 1995, p.29). Danso and McDonald (2001) describe this mutual interaction as follows: "The press translates the dominant ideology into a public opinion and, by doing so, helps structure public perception and legitimizes the actions of state institutions" (p.131). They further explain that by the uncritical (re)production of anti-immigrant discourses media create

> a feedback loop to bureaucrats and policymakers as to the legitimacy and "correctness" of what they are saying. When combined with the highly xenophobic attitudes of the population at large, this self-reinforcing mechanism serves to foreclose more progressive policy options and acts to stifle (and even shut down) more informed public debates on the issues (Danso & McDonald, 2001, p.132).

These authors argue that the media cannot take all the blame for the status of immigration-relevant policies. However, they are responsible for offering critical evaluation and contextualization of information within the broader immigration debates "rather than blindly reproducing statistics and 'moral indignation'" (Danso & McDonald, 2001, p.132).

The example of immigrant TB coverage shows that even the passage of time between the last century and this one has not changed the notion of immigrants as the "disease-carrying embodiment of danger whose presence poses a significant threat to the moral, physical and economic being of 'legitimate' Canadians" (Greenberg, 2000, p.12). The findings of this current study illustrate that the contemporary Canadian press adheres to the old template of representing immigrants. It follows an ideologically underpinned "immigrant script" according to which the topics considered most relevant are concerned with the negative evaluation of immigrants' real or presumed differences (van Dijk, 1999). Immigrants' daily post-migration experiences and problems such as housing, employment, health and discrimination are covered minimally. In accordance with this script, immigrants are depicted as threats to Canadian culture and values, abusers of the hospitality of the native-born population, and fraudsters who cost Canadian tax-payers money.

There is a stunning similarity between the contemporary and past language in defining the immigration experience. Diane Francis, the editor of the *National Post*, made the following claim in 1999, in the context of an article about immigrant TB: "Through sheer incompetence, Ottawa is ruining lives, exposing Canadians to grave risks and

financing the creation of a criminal class that will hurt this country for years to come" (NP, 08/13/99). Dr. Helen MacMurchy, the first female intern at Toronto General Hospital and a very influential public health activist had made the following claim almost nine decades earlier:

> After ages will wonder at the stupidity of Government and a people which takes so much trouble to bring in immigrants from every corner of Europe and, for sheer lack of public thought, lets its own Canadian babies die in a quite unnecessary holocaust (MacMurchy, 1912, cited in the Toronto Star, 1999, L1)

The preservation of the racializing discourse of immigrant TB in public health and the press is no doubt exacerbated by immigrants' limited political power and the lack of resources available to immigrants to confront systemic discrimination and institutionalized racism (Anderson & Reimer Kirkham, 1998; Gandy & Zumla, 2003; Reitmanova & Gustafson 2008; Young, 1990). In a racist system, racialized minorities have very little power to influence and control the content of their representation in dominant mainstream press (van Dijk, 2001). Therefore this system creates an environment conducive to the production of more inaccurate information and stereotypes. It follows that feeding racial prejudice with stereotypes based on such inaccurate information is the essential mechanism for the continuation of the cycle of oppression.

It is possible that the Canadian press (re)produces the dominant public health discourse and fails to offer an alternative conception of the TB problem because the content is typically formulated by members of the dominant group whose opinions are regularly sought by journalists for their credibility (van Dijk, 2001, 1995). The findings show that 69% (n=187) of all articles quoted or used as the information source cite

members of the dominant groups who were typically public health officials, physicians, university professors, immigration officials, politicians, lawyers, social and community workers, the RCMP, and school officials. As I indicated earlier, I understand that some of these actors could be visible minority immigrants but their voices were not identified as such. These actors were either interviewed, or their opinions about the immigrant TB problem in Canada and its consequences and solutions were collected through their research, studies, releases and conferences. Only 4% (n=11) of articles gave limited space to a few immigrants to directly represent themselves. The issue of post-migration difficulties and poverty, as described in words of one visible minority immigrant woman, was presented only in 1 out of 273 articles. However, her account was not linked to the incidence of TB among immigrants in Canada. In some articles immigrants spoke through lawyers, social and community workers, university professors, and some left-leaning politicians who were championing their causes. These findings show that the current press contributes to the uneven access of people to the media. Limited access prevents immigrants from defining and explaining their situation by themselves to the mainstream media, which obscures the underlying social determinants of immigrant TB.

7.3 Dissemination plans

I am concerned about the impact of negative representation of immigrants in the Canadian press. Therefore I would like to disseminate my findings at workshops, conferences and in journal publications to interested journalists, policy makers, and members of the public concerned with ethical reporting. For instance, I would like to

approach and present my findings to provincial press councils whose aim is to "encourage the highest ethical and professional standards of journalism as well as consider complaints about the conduct of the press in the gathering and publication of news, opinion and advertising" (Alberta Press Council, n.d., n.p).

Equally important, I would like to deliver my findings through similar venues to Canadian public health organizations involved in developing TB prevention and control programs since my findings speak to current TB control policies. I have already disseminated some preliminary findings through journal and conference publications which list can be found in the Appendix 4. My recommendations for the identified research audiences are described in the section that follows.

7.4 Recommendations

In the following paragraphs I propose several recommendations directed to public health decision makers and service providers as well as newspaper reporters, journalists and editors.

Public health

1. According to de Waal (2008) "health control at the border is demonstrable outmoded: it is both ineffective at controlling threats to public health and an inefficient allocation of resources" (p.345). In Welshman and Bashford's (2006) words, TB control based on screening is "often more about migration and asylum politics rather than the public health" (p.284). I recommend that the efficient immigrant TB control take into serious consideration the social determinants of immigrants' health status and their post-

migration experience (Ho, 2003; King, 2003; Littleton et al, 2008). Colleagues from New Zealand correctly argue that "the circumstances that promote the reactivation of latent TB infection in migrant communities, including migrants' experiences in transit and after arrival, structural conditions, and personal characteristics" may be more important than border control (Littleton et al., 2008, p.142). They understand that for sound prevention, attention must be paid to "the conditions for migrants, rather than placing a singular focus on place of birth" (p.142). Effective policies would consider health "within the context of gender roles, access to social and economic capital, the geopolitical environment, cultural values and the impact of racism, sexism and ageism" (Spitzer, 2005b, p.80).

2. I recommend that public health researchers start their research on social determinants of immigrant TB in Canada by collecting information about socio-economic circumstances of immigrants who develop active TB. This information is currently absent in Active TB Case Report Form (Appendix 3). Such information may inform future revisions of TB control policies that intend to be responsive to immigrants' health-related needs.

3. I recommend that researchers doing research about determinants of immigrant TB establish links with concerned policy makers and service providers because evidence-informed research per se currently does not have a direct influence on policymaking due to a variety of political, organizational, financial and other factors (Black, 2001; Lomas, 2000). Successful research implementation depends also on the context in which the proposed new policy is to be implemented, and the mechanisms by which it is facilitated (Kitson, Harvey & McCormack, 1998). This means that new policies may get

implemented if the knowledge facilitation process is intensive and the environment receiving the research outcomes is conducive to change.

4. Based on Lomas's (2000) work on knowledge transfer, I recommend that researchers assess whether their research on immigrant TB reflects the values of policymakers, in particular, their interests (its importance to them), beliefs (their assumptions about what is happening) and ideologies (their views about how the world should be). The high attendance of decision makers at the 13th annual conference of the *International Union Against TB and Lung Disease* (called Reaching the Unreached: Eliminating TB Among Indigenous and Marginalized Populations) in Vancouver (BC) in February 2009, indicates that the environment in Canada's public health policy making may be open to utilize new research ideas relevant to TB of immigrants and other marginalized groups. Interest in immigrant TB control is not sufficient for implementing the required policy changes. The effective research uptake requires that researchers actively engage at the earliest stages with policy makers to garner support developing dissemination and implementation plans (Choi, McQueen & Rootman, 2003).

5. In order to facilitate the uptake of their research, I recommend that researchers develop actionable messages in concise appealing format, and involve opinion leaders or "trusted sources" to endorse or communicate their research findings directly to decision makers (Dobbins, Ciliska, Cockerill, Barnsley & DiCenso, 2002; Reitmanova, 2009).

In conclusion, this complex interaction between researchers and policy makers should accelerate the outcomes of TB research for immigrants through more effective policies and services. Such policies would insure that immigrant health issues in general

and TB in particular are not addressed in isolation from socio-economic factors such as employment, economic security, affordable housing and address feelings of respect, dignity and social inclusion. In addition, a similar approach which considers the complex interaction between social factors and health should be also reflected in policies tackling the health inequalities of other marginalized and impoverished groups whose life circumstances put them at high risk of developing TB.

Media

1. I recommend in an agreement with Henry & Tator (2000), ter Wal (2002) and van Dijk (1999) that the practices and products of our media and media works need to be scrutinized by media monitoring. Van Dijk (1999) defined media monitoring as "a series of observational analytical, evaluative, and critical activities by independent (non-media) organizations" which would be conducted "in the light of fairly generally accepted social, cultural, and political conceptions about the role of the media in society" (p.312). He explained that the aim of media monitoring is not censoring the freedom of reporting "but to persuade media workers to adopt or enact recognized professional standards of quality, balance, fairness and social responsibility" (p.312). Critical analysis of the media practices and products may reveal the causes of unbalanced or biased reporting, which may include one of the following: inadequate education, uncritical use of sources, the absence of a code or policy, failing editorial control, or a lack of minority employees in the newsroom (van Dijk, 1999).

2. I am in agreement with Henry & Tator (2000), ter Wal (2002) and van Dijk (1999) who recommend that western countries such as Canada are in need of a large

reliable institution which would carry out critical media monitoring. There are many small media monitoring businesses in Canada (see *Canadian Business Directory* at www.canadianbusinessdirectory.ca), however, there is no independent non-profit institution with an academic expertise and governmental funding established. Such an institution could follow an example of the commission of experts for the monitoring of ethnocentrism, racism and xenophobia (*IMRAX*) which was set up by the *International Federation of Journalists* in Brussels (van Dijk, 1999). For instance, *IMRAX* annually awards several journalists for engaging in outstanding multicultural practice.

3. I recommend the re-imagining of Canadian media towards what van Dijk (1999) calls "truly multicultural media" (p.311) would require the personal involvement of journalists and their educational institutions which should provide students with proper knowledge and training on the coverage of minority affairs.

4. Finally, I recommend that organizations which represent immigrants and other minorities in Canada set up their own media monitoring practice as ter Wal (2002) suggested in her study on the representation of immigrants in the European press. This, of course, may be challenging because minoritized groups typically have very limited resources and support to engage in political action. The *Canadian Islamic Congress* which is involved in Canadian media monitoring is one example (Henry & Tator, 2000).

7.5 Future research

This last section discusses several directions I recommend for future research. While some of these directions are relevant to public health research about the problem of

immigrant TB, others are pertinent to research on the social representation of minorities and immigrants in Canada.

1. This work identified a misguided approach to immigrant TB control which focuses on screening and surveillance of immigrants exposed to TB infection in their countries of birth. There is a great need for health research which would investigate more rigorously the social determinants of immigrant TB and thereby provide evidence to inform future public health policies. Such studies are almost non-existent in Canada since researchers collect only limited data on the country of origin, age and gender of immigrants with active TB (Langlois-Klassen, Wooldrage, Manfreda, Ellis, Phypers, Gushulak et al., 2009). More research is needed to explain why the rate of active TB does not decrease but remains high despite active screening. Such studies may also provide much needed information for developing an alternative conception of this infectious disease.

2. Because of the unbalanced and inaccurate representation of immigrant TB, I recommend conducting more research that would explore possible links between the diverse health outcomes of immigrants and social, economic, cultural and political factors. Such studies may generate better understanding of health inequalities experienced by both immigrant women and men.

3. Regarding the social representation of immigrants in the Canadian press, future research might investigate, for instance, the relationship (if any) between media reports and diverse immigration-relevant events in Canada. As I have indicated in Chapter 5, the number of reports about immigrant TB has significantly decreased in the past decade. I

suggested that a possible reason for this trend may be the media's attention on other presumed immigrant threats, such as terrorism, SARS or cultural differences. Studies examining the relationship between these events and media reporting could be useful in identifying (and ultimately addressing) public discourses about immigrants (re)produced in the media.

4. My research indicates that there is lack of information about the coverage of immigrant issues as published in the media run by immigrants and ethnic minorities. This coverage could serve as an important source of exploring alternative discursive knowledge about the issues prioritized by our immigrants from their own perspective.

5. Another important direction which researchers could pursue in the future is to examine the reception and the impact of immigrant representation by diverse media audiences.

7.6 Summary

In conclusion, the study findings show that the Canadian press (re)produces and reinforces public discourses embedded in long-standing ideologies about race and nationhood that have framed the lives and social representation of immigrants in Canada for the past 150 years. Racializing TB and its carriers highlights the dual focus of TB control: guarding the health of the nation at the borders by excluding the sick and by monitoring of those immigrants already in the country. By neglecting social determinants of immigrant TB and reasons for their unequal distribution, the current TB control policies perpetuate the high burden of TB in the immigrant population. By unmasking

these racializing discourses and explaining the mechanisms, practices and power relations responsible for (re)production of health and social inequalities of immigrants, my study contributes to exposing everyday institutionalized racism in Canada, which is the first step towards its elimination. By exposing the racializing character of immigrant TB control, this study calls for the development of new policies which would address social factors underlying immigrants' health inequalities. Without the understanding of the role that historic and current discrimination plays in the health inequalities of oppressed people such as visible minority immigrants, their undesirable health outcomes will continue "to be attributed to their cultures and to their difference from the 'mainstream'" (Anderson & Reimer Kirkham, 1998, p.256). Finally, professor Keith Wailoo (1995), Director of the Center for Race and Ethnicity at Rutgers University, stated in a 1995 PBS TV documentary that "tuberculosis is more than biology; it is a statement about society" (cited in Grzybowski & Allen, 1999, p.1025). And this study confirms just that.

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Appendix 1: List of disseminated work

Journal Articles

[R] indicates peer-reviewed

1. [R] **Reitmanova, S.** (2009). "Disease-breeders" among us: Deconstructing race and ethnicity as risk factors of immigrant ill health. *Journal of Medical Humanities, 30*(3): 183-90.

2. [R] **Reitmanova, S.** (2008). Saving the Empire: The politics of immigrant TB in Canada. *McGill Journal of Medicine, 11*(2): 199-203.

Letters to the Editor

1. **Reitmanova, S.** (2009). Immigrant TB: Beyond screening and surveillance. (Letter to the Editor). *The Lancet Infectious Diseases, 9*(10): 584-85.

Conference Presentations

1. [R] **Reitmanova, S.** (2009). Immigrant TB: Are screening and surveillance the only answers? *Reaching the Unreached: Eliminating TB Among Indigenous and Marginalized Populations. International Union Against TB and Lung Disease (North American Region) Annual Conference*, Vancouver, Canada, Feb 26-28.

2. [R] **Reitmanova, S.** (2008). The Colour of the White Plague: Constructing the Immigrant Identity in the Canadian Press. *Second International Conference on Critical Approaches to Discourse Analysis Across Disciplines (CADAAD).*, University of Hertfordshire, Hertfordshire, UK, July 10-12.

University Seminars

1. **Reitmanova, S.** (2007). "Typhoid Marys in our midst": Representation of immigrant TB in Canadian daily newspapers. Community Health & Humanities, Memorial University, St. John's, NL, Canada, October 31

Appendix 2: TB drug regimens

TB drug regimens (Health Canada, 2000)

Regimen	Intensive phase	Continuing phase	Total duration of months	Number of doses
INH/RMP/PZA +/- EMB	2	4	6	95
INH/RMP/ +/- EMB	1-2	7-8	9	120

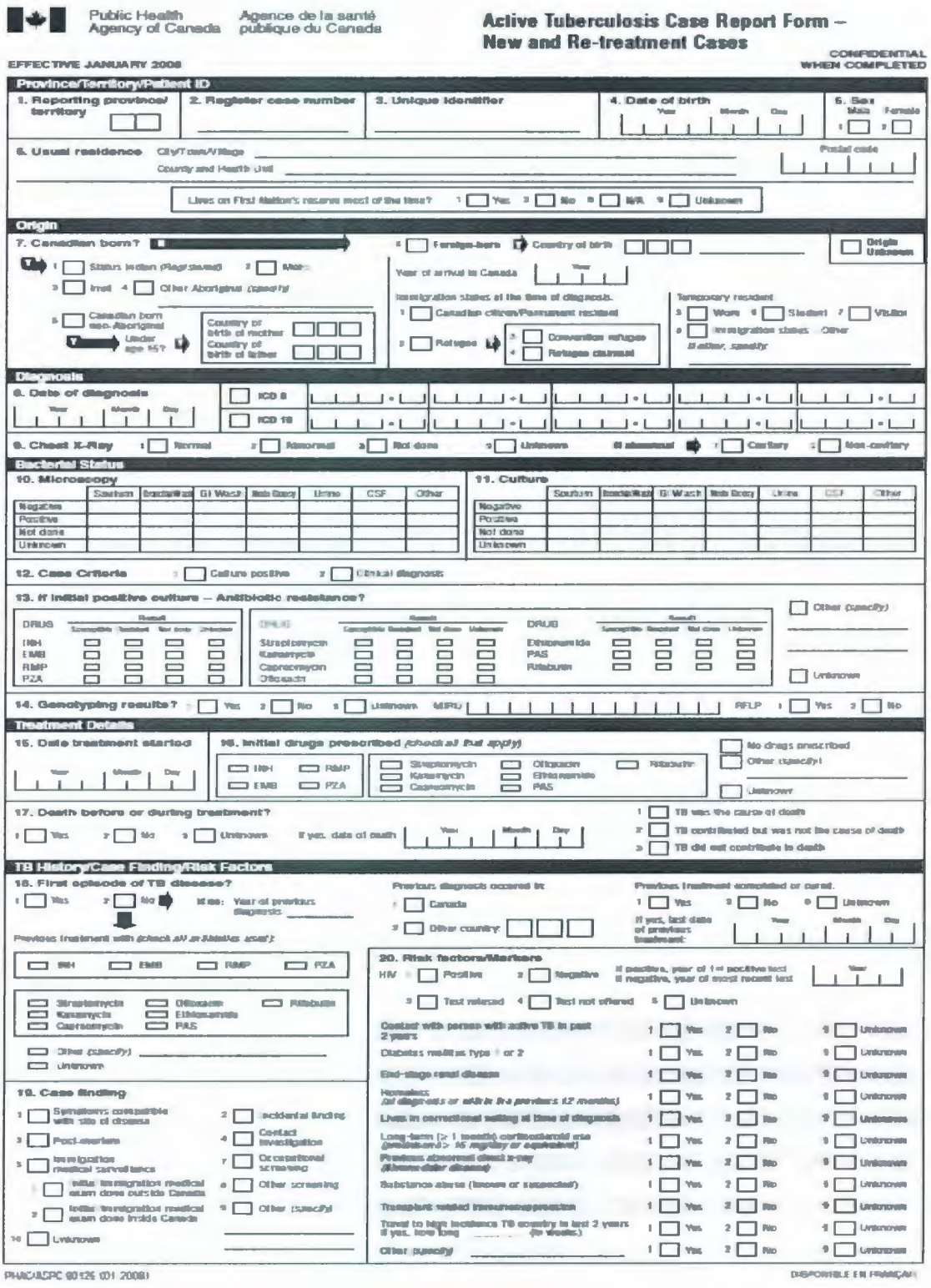
INH – Isoniazid

RMP – Rifampicin

PZA – Pyrazinamide

EMB – Ethambutol

Appendix 3: Active TB case report form



Public Health Agency of Canada / Agence de la santé publique du Canada

Active Tuberculosis Case Report Form – New and Re-treatment Cases

EFFECTIVE JANUARY 2008

CONFIDENTIAL WHEN COMPLETED

Province/Territory/Patient ID

1. Reporting province/territory
2. Register case number
3. Unique identifier
4. Date of birth (Year / Month / Day)
5. Sex (Male / Female)
6. Usual residence (City/Town/Village; Country and Health Unit; Postal code)
Lives on First Nation's reserve most of the time? (Yes / No / N/A / Unknown)

Origin

7. Canadian born? (Yes / No – Foreign-born → Country of birth / Origin Unknown)
Status Indian (Registered) / Métis / Inuit / Other Aboriginal (specify)
Canadian born non-Aboriginal → Under age 15? → Country of birth of mother / Country of birth of father
Year of arrival in Canada
Immigration status at the time of diagnosis: Canadian citizen/Permanent resident; Refugee (Convention refugee / Refugee claimant)
Temporary resident: Work / Student / Visitor; Immigration status: Other (If other, specify)

Diagnosis

8. Date of diagnosis (Year / Month / Day)
ICD 9 / ICD 10
9. Chest X-Ray (Normal / Abnormal / Not done / Unknown; If abnormal: Cavitary / Non-cavitary)

Bacterial Status

10. Microscopy

	Sputum	Bronchial wash	GI Wash	Pleural fluid	Urine	CSF	Other
Negative							
Positive							
Not done							
Unknown							

11. Culture

	Sputum	Bronchial wash	GI Wash	Pleural fluid	Urine	CSF	Other
Negative							
Positive							
Not done							
Unknown							

12. Case Criteria (Culture positive / Clinical diagnosis)

13. If initial positive culture – Antibiotic resistance?

DRUG	Result: Susceptible	Resistant	Not done	Unknown
INH				
EMB				
RMP				
PZA				
Streptomycin				
Kanamycin				
Capreomycin				
Ofloxacin				
Ethionamide				
PAS				
Rifabutin				

Other (specify) / Unknown

14. Genotyping results? (Yes / No / Unknown) MIRU / RFLP (Yes / No)

Treatment Details

15. Date treatment started (Year / Month / Day)
16. Initial drugs prescribed (check all that apply): INH / RMP / EMB / PZA / Streptomycin / Ofloxacin / Rifabutin / Kanamycin / Ethionamide / Capreomycin / PAS
No drugs prescribed / Other (specify) / Unknown
17. Death before or during treatment? (Yes / No / Unknown) If yes, date of death (Year / Month / Day)
TB was the cause of death / TB contributed but was not the cause of death / TB did not contribute to death

TB History/Case Finding/Risk Factors

18. First episode of TB disease? (Yes / No → If no: Year of previous diagnosis)
Previous treatment with (check all antituberculosis agent): INH / EMB / RMP / PZA / Streptomycin / Ofloxacin / Rifabutin / Kanamycin / Ethionamide / Capreomycin / PAS / Other (specify) / Unknown
Previous diagnosis occurred in: Canada / Other country
Previous treatment completed or cured? (Yes / No / Unknown) If yes, last date of previous treatment: (Year / Month / Day)

19. Case finding
Symptoms compatible with site of disease / Incidental finding / Post-mortem / Contact investigation / Immigration medical surveillance / Occupational screening / Initial immigration medical exam done outside Canada / Other screening / Initial immigration medical exam done inside Canada / Other (specify) / Unknown

20. Risk factors/Markers
HIV (Positive / Negative / Test refused / Test not offered / Unknown) If positive, year of 1st positive test / If negative, year of most recent test (Year)

Contact with person with active TB in past 2 years	Yes	No	Unknown
Diabetes mellitus type 1 or 2	Yes	No	Unknown
End-stage renal disease	Yes	No	Unknown
Homeless (at diagnosis or within the previous 12 months)	Yes	No	Unknown
Lives in correctional setting at time of diagnosis	Yes	No	Unknown
Long-term (> 1 month) corticosteroid use (prednisone > 15 mg/day or equivalent)	Yes	No	Unknown
Previous abnormal chest x-ray (fibronodular disease)	Yes	No	Unknown
Substance abuse (known or suspected)	Yes	No	Unknown
Transplant related immunosuppression	Yes	No	Unknown
Travel to high incidence TB country in last 2 years (if yes, how long (in weeks))	Yes	No	Unknown
Other (specify)	Yes	No	Unknown

PHAC/ASPC 00126 (01-2008)

DISPONIBLE EN FRANÇAIS

Appendix 4: List of analyzed newspaper articles[14]

The Ottawa Citizen

OC1 Pregnant Dutch woman wins OHIP battle: Landed immigrant wouldn't submit to Canada's mandatory chest X-ray
March 16, 1999, CITY, Pg. D8, 519 words, Peter Hum

OC2 Replacement urged for 'useless' TB vaccine
May 28, 1999, NEWS, Pg. D18, 395 words, Jeff Heinrich

OC3 Group fuel racism, MPs say: Web site calls for end to immigration of non-white groups
August 21, 1999, NEWS, Pg.A3, 590 words, Tim Naumetz with files from Juliet O'Neill

OC4 Lepers and leaky borders
August 31, 1999, NEWS, Pg.A13, 630 words, Diane Francis

OC5 Sea to sea
September 28, 1999, NEWS, Pg.A7, 385 words

OC6 Civilian volunteers exposed to TB working with Kosovars: Aid agencies say all were told of health risks
September 29, 1999, NEWS, Pg.A5, 583 words, Jim Bronskill and Mike Blanchfield

OC7 TB cases are wrongly downplayed
October 1, 1999, NEWS, Pg.A15, 366 words, Cheryl Gallant

OC8 Immigration standards put Canadians' health, safety in danger
April 12, 2000, NEWS, Pg.A4, 556 words, Janice Tibbetts

OC9 TB is not cure: Many Canadians believe TB has been beaten, but that is far from the truth. Stubbornly refusing to die, it is not staging a deadly comeback
April 30, 2000, THE CITIZEN'S WEEKLY, Pg.C2, 4828 words, Elizabeth Payne

OC10 TB outbreak at Forces base ignored: MP. Elsie Wayne accuses military of neglecting victims
May 10, 2000, NEWS, Pg.A5, 564 words, Mike Blanchfield

OC11 Canada must help disease fight
June 20, 2000 CITY, Pg.B5, 273 words, Stephen St. Denis

OC12 Serious disease threat
September 22, 2000, NEWS, Pg.A17, 209 words, Stephen St. Denis

OC13 Montreal man faces jail for failing to treat his TB
December 1, 2000, NEWS, Pg.A4, 283 words, George Kaogerakis

OC14 Man with drug resistant TB entered Canada undetected
December 5, 2000, NEWS, Pg.A6, 200 words

[14] The list format was automatically generated by newspaper search engines and therefore this format varies by different newspapers.

OC15 Immigrant who carried dangerous TB to Canada sues federal government
December 29, 2000, NEWS, Pg.A5, 370 words

OC16 Immigration to Canada exceeds projections
January 20, 2001, NEWS, Pg. A16, 807 words

OC17 MD says federal government lax in warning provinces of TB cases
April 12, 2001, NEWS, Pg.A3, 251 words, Joanne Laucius

OC18 Public health paper chase
April 14, 2001, NEWS, Pg.B5, 305 words

OC19 Lock them up
October 2, 2001, NEWS, Pg.A15, 169 words, Guy Chenevert

OC20 Antibiotic-resistant diseases pose 'urgent' problem: specialists. Health care tab could rise $1.8B unless action taken, panel warns
October 8, 2002, NEWS, Pg.A6, 681 words, Norma Greenaway

OC21 Casino food worker treated for TB: No health threat, officials say
April 16, 2003, CITY, Pg.C1, 408 words

OC22 We can't let down our guard on disease control
May 6, 2003, NEWS, Pg.A16, 1061 words, Berry Dworkin

OC23 Inactive TB not revealed to refugee claimants
May 28, 2003, NEWS, Pg.A6, 303 words, Elizabeth Thompson

OC24 Immigrant women don't stay healthy in Canada: study. 'McDonald's effect' leads them to take up bad habits
October 1, 2003, NEWS, Pg.A5, 568 words, Kate Jaimet

OC25 Auditor blasts Ontario's inadequacies: Backlogs, other failures join list of previously reported deficiencies
December 3, 2003, NEWS, Pg.A3, 663 words, April Lindgren

OC26 Officials monitor TB patient's contacts: Tests show two people who were in contact with ill immigrant need to be watched
June 23, 2005, CITY, Pg.B3, 621 words, Carrie Kristal-Schroder

OC27 Track newcomers: terror expert: Ex-CSIS planner calls for use of criminal-type electronic bracelets
August 23, 2005, CITY, Pg.C3, 885 words, Gary Dimmock

OC28 Montreal lab workers test positive for TB: Controversial New Jersey company at centre of probe by U.S. Senate
March 9, 2006, BUSINESS, Pg. D2, 452 words, David Evan

The Ottawa Sun

OS1 HUMAN CARGO NETTED OFF B.C. AUTHORITIES SUSPECT HUMAN SMUGGLING OPERATION
July 21, 1999, Wednesday, NEWS, 333 words

OS2 LEADERS FLOG ONE-CITY PLAN
August 5, 1999, Thursday, NEWS, 369 words

OS3 A GOVERNMENT IN HIDING THE LIBERALS ARE GIVING THE HOUSE A WIDE BERTH, AND NO WONDER -- IF PARLIAMENTWERE SITTING, THEY MIGHT HAVE TO ANSWER SOME PESKY QUESTIONS FROM THEOPPOSITION
September 9, 1999, Thursday, EDITORIAL/OPINION, 746 words, Mark Bonokoski

OS4 PM SHRUGS OFF TB FEARS
September 29, 1999, Wednesday, NEWS, 330 words, Anne Dawson

OS5 TB
September 29, 1999, Wednesday, EDITORIAL/OPINION, 387 words

OS6 TB OR NOT TB? THAT IS THE QUESTION -- IS IT NOBLER IN THE MIND TO SUFFER THE SLINGS ANDARROWS OF OUTRAGED RED CROSS VOLUNTEERS AND ROYAL AIRLINES STAFFERS, OR IS CHRETIEN JUST OUT OF HIS GOURD?
September 30, 1999, Thursday, EDITORIAL/OPINION, 743 words, Mark Bonokoski

OS7 AIRLINE BALKS AT TB FAULT
October 1, 1999, Friday, NEWS, 162 words

OS8 LETTERS TO THE EDITOR COLUMN
October 2, 1999, Saturday, COMMENT, 336 words, Cheryl Gallant

OS9 LETTER OF THE DAY COLUMN
October 2, 1999, Saturday, COMMENT, 309 words, Ross Reid and Pierre H. Juneau

OS10 OUTBREAK WHEN IT COMES TO INFECTIOUS DISEASES, EVERYONE IS AT RISK
October 9, 1999, Saturday, NEWS, 1057 words, Jason Botchford

OS11 IMPROPER MIGRANT MONITORING CREATES HEALTH RISK
June 26, 2000, Monday, NEWS, 167 words

OS12 MP DEMANDS HIV TESTS CALLS FOR TOUGHER IMMIGRANT SCREENING
September 21, 2000, Thursday, NEWS, 246 words, Stephanie Rubec

OS13 IMMIGRANTS TO FACE TOUGH TEST HIV, HEP B EXAMS FOR NEWCOMERS
December 4, 2000, Monday, NEWS, 315 words

OS14 FEDS GOOFED ON TB MISDIAGNOSIS CITED FOR ALLOWING INFECTED MAN INTO COUNTRY
December 5, 2000, Tuesday, NEWS, 350 words, Stephanie Rubec

OS15 A FEW BUGS IN IMMIGRATION
January 28, 2001, Sunday, COMMENT, 696 words, Greg Weston

OS16 SICK IMMIGRANTS NOT TRACKED; OFFICIALS UNAWARE OF TB RISK: MINISTER
May 15, 2001 Tuesday, News; 272 words, Stephanie Rubec

OS17 DETAIN UNDOCUMENTED REFUGEES: IMMIGRATION UNION
December 9, 2001 Sunday, News; 249 words

OS18 LETTER OF THE DAY COLUMN
January 3, 2002 Thursday, Comment; 219 words, Rudy Fernandes

OS19 AROMATHERAPY DEMENTIA AID
December 7, 2002 Saturday, Health; 294 words

OS20 AG RAISES RED FLAG OVER ILL IMMIGRANTS; PARLIAMENT HILL
May 28, 2003 Wednesday Final Edition, NEWS; Pg. 24, 441 words, Stephanie Rubec

The Toronto Star

TS1 'HEALTH CUTS KILLED MY WIFE'
March 23, 1999, Tuesday, Edition 1, 637 words, Joel Ruimy

TS2 STUDY PROBES WEAKNESS OF AGING TB VACCINE
June 4, 1999, Friday, Edition 1, 493 words

TS3 ST. CATHARINES
August 5, 1999, Thursday, Edition 1, 221 words

TS4 NEW BRUNSWICK
August 28, 1999, Saturday, Edition 1, 357 words

TS5 TB INFECTS 9 TIBETANS
September 10, 1999, Friday, Edition 1, 354 words, Ariel Teplitsky

TS6 TB HITS 6 KOSOVO MERCY FLIGHT ATTENDANTS
September 27, 1999, Monday, Edition 1, 245 words

TS7 VOLUNTEER WHO GOT TB SAYS OTTAWA'S TO BLAME
September 28, 1999, Tuesday, Edition 1, 948 words, Peter Small

TS8 LIBERAL MINISTER DEFENDS DISEASE SCREENING PROCESS
September 29, 1999, Wednesday, Edition 1, 623 words, Allan Thompson

TS9 COLLINGWOOD
September 30, 1999, Thursday, Edition 1, 227 words

TS10 STORE WORKER PUT ON LEAVE AFTER TESTING POSITIVE FOR TB
October 1, 1999, Friday, Edition 1, 652 words, Peter Small

TS11 NO NEED FOR PANIC OVER TB
October 3, 1999, Sunday, Edition 1, 566 words

TS12 WOMAN'S FAMILY CLEAR OF TB
October 4, 1999, Monday, Edition 1, 130 words

TS13 ALL REFUGEES SHOULD BE IMMUNIZED UPON ARRIVAL
October 8, 1999, Friday, Edition 1, 341 words

TS14 LETTER OF THE DAY HYSTERIA OVER TB WON'T HELP ANYONE
October 10, 1999, Sunday, Edition 1, 201 words

TS15 FEARS MOUNTING OVER TB-POSITIVE MIGRANTS
October 16, 1999, Saturday, Edition 1, 467 words, Tim Harper

TS16 WORLD PUT ON ALERT AS TB SPREADS
October 29, 1999, Friday, Edition 1, 360 words

TS17 VOLUNTEER SUES OVER TB INFECTION
March 3, 2000, Friday, Edition 1, 215 words

TS18 UNFAIR TREATMENT OF TIBETAN REFUGEES
May 31, 2000, Wednesday, Edition 1, 642 words, Anil Mathew Varughese

TS19 MONITORING OF MIGRANTS SAID TO POSE HEALTH RISK
June 26, 2000, Monday, Edition 1, 690 words

TS20 KEEP TABS ON IMMIGRANTS' RISK OF TB, SAYS STUDY
October 3, 2000, Tuesday, Edition 1, 301 words, Tanya Talaga

TS21 IMMIGRANTS FACE NEW SCREENING FOR DISEASE
December 3, 2000, Sunday, Edition 1, 2339 words, Lynda Hurst

TS22 CANADA ADMITTED MAN WITH DEADLY TB
December 4, 2000, Monday, Edition 1, 858 words, Joanna Frketich

TS23 DOCTOR MISSED TB IN X-RAY: OTTAWA
December 5, 2000, Tuesday, Edition 1, 552 words

TS24 T.O. RESIDENTS BEING CHECKED
December 5, 2000, Tuesday, Edition 1, 338 words, Tanya Talaga

TS25 TB CASE PROMPTS SCREENING REVIEW
December 25, 2000, Monday, Edition 1, 835 words, Joanna Frketich

TS26 TB CARRIER, THREE OTHERS SUE OTTAWA
December 29, 2000, Friday, Edition 1, 336 words, Joanna Frketich

TS27 CARRIER SHOULD SUE OWN COUNTRY
January 5, 2001, Friday, Edition 1, 292 words

TS28 1,700 MDS SET FOR AUDIT
January 23, 2001, Tuesday, Edition 1, 369 words

TS29 $9M URGED TO BOOST CITY HEALTH
January 23, 2001, Tuesday, Edition 1, 765 words, Paul Moloney

TS30 HEALTH WARNING
January 24, 2001, Wednesday, Edition 1, 346 words

TS31 KITCHENER
March 14, 2001, Wednesday, Edition 1, 206 words

TS32 Toronto needs money to fight TB now
January 11, 2002 Friday, 805 words

TS33 Immigrant TB checks strain local resources
February 22, 2002 Friday, 292 words, Peter Edwards

TS34 We must act globally
March 15, 2002 Friday, 294 words, Mike Hutchings

TS35 On the front lines
March 30, 2002 Saturday, 1892 words, Elaine Carey

TS36 Open arms, closed coffers
March 30, 2002 Saturday, 1142 words, Elaine Carey

TS37 Study slams TB monitoring system
April 20, 2002 Saturday, 579 words, Suzanne Morrison

TS38 Health centre at border will aid refugees
May 2, 2002 Thursday, 409 words, Suzanne Morrison

TS39 Screen for dormant TB: Study
December 5, 2002 Thursday, 428 words, Prithi Yelaja

TS40 Disease must be flagged at border, auditor says
May 28, 2003 Wednesday, 336 words, Louise Elliott

TS41 Brief
September 7, 2004 Tuesday, NEWS; Pg. B03, 583 words

TS42 Fertile ground for TB
November 29, 2004 Monday, EDITORIAL; Pg. A18, 294 words

TS43 New TB cases found
December 10, 2004 Friday, NEWS; Pg. B01, 920 words, Moira Welsh

TS44 Can expect to see more social unrest
January 26, 2005 Wednesday, LETTER; Pg. A23, 252 words

TS45 Track newcomers with TB, OMA says
January 31, 2006 Tuesday, NEWS; Pg. B07, 301 words

TS46 Drug trial volunteer tests positive for TB
March 9, 2006 Thursday, NEWS; Pg. A11, 326 words, Leslie Ferenc

TS47 TB a disease of the poor, experts say
March 25, 2006 Saturday, NEWS; Pg. A14, 469 words

TS48 Future health rosier?Healthy outlook Some promising statistics
June 24, 2006 Saturday, LIFE; Pg. L01, 1509 words, Rita Daly

TS49 A disease of the past still lingers in Canada
September 30, 2006 Saturday, NATIONAL REPORT; Pg. F03, 860 words, Megan Ogilvie

TS50 Defenceless against a world of TB; Toronto, with its growing immigrant population, will likely see an increase of deadly, contagious TB, experts say. The current system simply couldn't handle an outbreak, but the province has yet to make the changes required to protect its citizens
February 24, 2008 Sunday, NEWS; Pg. A08, 2030 words, Megan Ogilvie

The Globe and Mail

GM1 City facing health threats, board told
January 26, 1999 Tuesday, TORONTO NEWS; Pg. A15, 371 words, Wallace Immen

GM2 Board seeks funds to fight TB Number of cases increasing in Toronto, city's medical chief warns
February 23, 1999 Tuesday, NATIONAL NEWS; Pg. A13, 387 words, Gay Abbate

GM3 Governments' efforts for homeless fall short
March 25, 1999 Thursday, COLUMN; Pg. A13, 696 words, Michael Valpy

GM4 Kosovo refugees spend peaceful 1st day in Canada. While many have stories of terror to tell, they also express desire to return after war
May 6, 1999 Thursday, INTERNATIONAL NEWS; CONFLICT IN THE BALKANS; Pg. A17, 719 words, Brian Laghi

GM5 A guide to the arriving Kosovo refugees. How's their health? Do they pose a threat to Canadian security? Well, it depends
May 7, 1999 Friday, COMMENTARY; Pg. A17, 912 words, Morton Beiser

GM6 No-name ship found crammed with Asians. Suspicious Canadian authorities intercept rusted, listing vessel off Vancouver Island
July 21, 1999 Wednesday, NATIONAL NEWS; Pg. A1, 873 words, Jane Armstrong

GM7 Tibet refugees may carry deadly TB. Five claimants in quarantine; immigration officers threaten walkout over disease fears
September 7, 1999 Tuesday, NATIONAL NEWS; Pg. A1, 934 words, Estanislao Oziewicz

GM8 Medical exams ordered for Tibetan refugees. TB threat prompts change in claimant procedure
September 8, 1999 Wednesday, NATIONAL NEWS; Pg. A2, 547 words, Graham Fraser

GM9 Where public health clashes with refugee claims Carrying a potentially fatal communicable disease is reason to be kept out
September 9, 1999 Thursday, EDITORIAL; Pg. A14, 584 words

GM10 TB risks
The Globe and Mail (Canada), September 10, 1999 Friday, LETTER TO THE EDITOR; Pg. A10, 124 words, W. Harding le Riche

GM11 TB is worldwide problem
September 13, 1999 Monday, LETTER TO THE EDITOR; Pg. A10, 159 words, Patricia Warwick

GM12 TB and public health
September 16, 1999 Thursday, LETTER TO THE EDITOR; Pg. A18, 148 words, George Haeh

GM13 Protecting ourselves
September 22, 1999 Wednesday, LETTER TO THE EDITOR; Pg. A14, 188 words, Kate Pelton

GM14 Immigrants with TB drain health budget
September 22, 1999 Wednesday, TORONTO NEWS; Pg. A12, 364 words, James Rusk

GM15 Health agency believes man spreading TB found
September 23, 1999 Thursday, TORONTO NEWS; Pg. A11, 518 words, James Rusk

GM16 Six mercy-flight attendants contract TB. Two infected crew members who travelled on Kosovo rescue missions seeking compensation
September 28, 1999 Tuesday, NATIONAL NEWS; Pg. A3, 643 words, Estanislao Oziewicz

GM17 Vigilance required to ensure TB recovery. Potential growth of drug resistant strains means some patients must be monitored to see that medication is taken
September 29, 1999 Wednesday, NATIONAL NEWS; Pg. A6, 614 words, Krista Foss

GM18 Chrétien dismisses potential TB threat. Won't be tested despite risk of contagion
September 29, 1999 Wednesday, NATIONAL NEWS; Pg. A6, 327 words, Daniel Leblanc

GM19 On TB and menopause, for the record
September 30, 1999 Thursday, COLUMN; Pg. A14, 682 words, Michael Valpy

GM20 Chinese migrants smuggled into Toronto's Pearson airport
October 15, 1999 Friday, NATIONAL NEWS; Pg. A7, 373 words, Estanislao Oziewicz

GM21 TB, teen-pregnancy rate high in Toronto. City also has greater incidence of AIDS than rest of province, report shows
December 1, 1999 Wednesday, TORONTO NEWS; Pg. A23, 426 words, Natalie Southworth

GM22 Border-crossing germs
March 24, 2000 Friday, LETTER TO THE EDITOR; Pg. A18, 127 words, Pamela Walden-Landry

GM23 City says it needs help to beat TB; Number of people with strains; resistant to drug treatment growing
March 25, 2000 Saturday, TORONTO NEWS; Pg. A29, 397 words, Hamida Ghafour

GM24 The war on TB continues
May 3, 2000 Wednesday, ADVERTISING SPECIAL REPORT; FOCUS ON LUNG HEALTH; Pg. L1, 748 words

GM25 Military disputes MP's TB diagnosis
May 10, 2000 Wednesday, NATIONAL NEWS; NATIONAL REPORT; Pg. A8, 76 words

GM26 Health monitoring of immigrants flawed: report
June 26, 2000 Monday, NATIONAL NEWS; Pg. A2, 223 words, Dene Moore

GM27 NEWS INDEX: MONDAY, JUNE 26, 2000
June 26, 2000 Monday, NEWS INDEX; Pg. A1, 142 words

GM28 Globe-trotting diseases
June 27, 2000 Tuesday, LETTER TO THE EDITOR; Pg. A14, 153 words, Michael Willems

GM29 Man with TB faces jail for refusing treatment; Montreal officials seeking incarceration; on grounds he's a danger to the public
November 30, 2000 Thursday, NATIONAL NEWS; Pg. A3, 484 words, Andre Picard

GM30 Judge tells man with TB he must take treatment
December 1, 2000 Friday, NATIONAL NEWS; Pg. A9, 449 words, Tu Thanh Ha

GM31 Man could be jailed if he skips TB pills; Patient with resistant strain of disease; drinks heavily, has missed appointments
December 5, 2000 Tuesday, NATIONAL NEWS; Pg. A12, 357 words, Tu Thanh Ha

GM32 Dozens exposed to resistant TB
December 5, 2000 Tuesday, NATIONAL NEWS; Pg. A12, 1226 words, Walace Immen and Ken Kilpatrick

GM33 How to fight TB
December 5, 2000 Tuesday, EDITORIAL; Pg. A20, 404 words

GM34 TB-infected man sues Ottawa; Immigrant who may have exposed dozens; says officials shouldn't have let him in
December 29, 2000 Friday, NATIONAL NEWS; Pg. A6, 445 words

GM35 TB-infected man files lawsuit
January 18, 2001 Thursday, NATIONAL NEWS; Pg. A7, 211 words, Ken Kilpatrick

GM36 HIV, TB rates troubling; Economic polarization puts immigrants; low-income families at risk, report says
January 22, 2001 Monday, TORONTO NEWS; Pg. A14, 712 words, Gay Abbate

GM37 Canada takes lead in battle against TB; Offers to set up global drug system
March 23, 2001 Friday, NATIONAL NEWS; Pg. A7, 518 words, Andre Picard

GM38 Health officials unaware of TB cases
April 12, 2001 Thursday, NATIONAL NEWS; Pg. A3, 301 words, Margaret Philp

GM39 35 migrants said to want refugee status
April 18, 2001 Wednesday, NATIONAL NEWS; ACROSS CANADA; Pg. A9, 80 words, Robert Matas

GM40 Cluster of TB cases found in men's hostel
November 28, 2001 Wednesday, TORONTO NEWS; Pg. A20, 423 words, Wallace Immen

GM41 Efforts against TB not good enough
April 24, 2002 Wednesday, COLUMN; Inside Toronto; Pg. A20, 700 words, John Barber

GM42 TB found in third Ontario newborn
April 26, 2002 Friday, TORONTO NEWS; Pg. A23, 379 words, Graeme Smith

GM43 Canada 2005?; The sanatoriums are long gone, but TB is not. It remains, public health reporter ANDRÉ PICARD warns, one of the world's great killers. Drug resistant TB costs a fortune to fight; and even wealthy nations aren't immune to a serious outbreak. 'It could happen in Toronto, if we're not careful,' one expert says
May 18, 2002 Saturday, FOCUS; Pg. F5, 3248 words, Andre Picard

GM44 Five border workers contract TB
July 13, 2002 Saturday, NATIONAL NEWS; Briefing; Pg. A9, 35 words

GM45 Ottawa failing to report inactive TB, auditor says
May 28, 2003 Wednesday, NATIONAL NEWS; Pg. A4, 424 words, Campbell Clark

GM46 TB still a threat in Canada, experts warn; 'Worldwide epidemic' could spread unless more is done to prevent cases overseas
March 25, 2006 Saturday, HEALTH; Pg. A9, 633 words, Sue Bailey

The National Post

NP1 Immigration: a costly nightmare: Those running the system have a lot to answer for
April 3, 1999 Saturday, FINANCIAL POST; Pg. D03, 797 words, Diane Francis

NP2 Canadian refugee policy for the dogs
August 14, 1999 Saturday, FINANCIAL POST; Pg. D03, 934 words, Diane Francis

NP3 These refugees and immigrants can be deadly: Adequate medical screening process doesn't exist
August 21, 1999 Saturday, FINANCIAL POST; Pg. D03, 1060 words, Diane Francis

NP4 Lax regulations are importing illness: Prudent steps need to be taken to protect public health
August 31, 1999 Tuesday, FINANCIAL POST; Pg. C03, 773 words, Diane Francis

NP5 Refusing treatment for TB may land Quebec man in prison: Montreal officials ask court to take action for good of the public
November 30, 2000, CANADA; Pg. A4, 468 words, Idella Sturino

NP6 Quebec: Refugee agrees to take medication for TB
December 5, 2000, CANADA: WEST TO EAST; Pg. A11, 66 words

NP7 Doctor misread X-ray of immigrant with TB: Lived in Hamilton: A thousand people will be tested for TB
December 5, 2000, TORONTO; Pg. A21, 630 words, Jennifer Prittie and Mark Gollom

NP8 Immigrant with TB to sue Ottawa for letting him in: Seeks $500-million for federal doctor's incorrect diagnosis
December 29, 2000, NEWS; Pg. A1, 577 words, Mary Vallis, with files from Finbarr O'Reilly

NP9 Scrutinizing wealth and health: Immigration and RRSP rules need adjustment
March 24, 2001 Saturday, FINANCIAL POST: NEWS; Pg. D03, 801 words, Diane Francis

NP10 Provinces not told of TB risks in immigrants: study
April 12, 2001, CANADA; Pg. A4, 367 words, Heather Sokoloff

NP11 Ottawa imports drug dealers and taxpayers pay the price: One mayor invoices Ottawa monthly, without success
June 30, 2001 Saturday, FINANCIAL POST: NEWS; Pg. C03, 695 words, Diane Francis

NP12 Ottawa's tightwad refugee stance: Overriding principle is this: Make everyone else pay
July 07, 2001 Saturday, FINANCIAL POST: NEWS; Pg. C03, 831 words, Diane Francis

NP13 Canada gets well-deserved U.S. snub: Our neighbour's upset over our loose refugee system
September 22, 2001 Saturday, FINANCIAL POST; Pg. C03, 660 words, Diane Francis

NP14 Canada: Back door to America: Bush snubs Chretien in U.S. anger over our border security (All but Toronto headline); Canada remains the perilous back door to America: Bush snubs Chretien in U.S. anger over our lackadaisical border security (Toronto edition headline)
October 23, 2001 Tuesday, FINANCIAL POST: NEWS; Pg. FP3, 818 words, Diane Francis

NP15 Some immigration answers
November 05, 2001 Monday, FINANCIAL POST: EDITORIAL; Pg. FP17, 710 words, Joel S. Guberman

NP16 System fails to monitor TB influx: Report shows little tracking, less treatment for thousands of infected immigrants
May 2, 2002, NEWS; Pg. A1, 1019 words, Adrian Humphreys

NP17 TB diagnosis often missed: Study finds doctors not used to seeing deadly lung disease
May 3, 2002, CANADA; Pg. A5, 545 words, Adrian Humphreys

NP18 Quebec: Border-crossing staff being tested for TB
July 13, 2002, CANADA: WEST TO EAST; Pg. A05, 73 words

NP19 Ancient killer still with us: Consumption may seem like a disease of the past, but some 400 people are treated each year in Toronto
February 15, 2003, TORONTO; Pg. TO11, 1026 words, Nate Hendley

NP20 Ottawa's tracking of TB cases criticized: Auditor-General finds gaps and fraud in immigration
May 28, 2003, NEWS; Pg. A1, 842 words, Andrew McIntosh

NP21 Refugees and TB
May 31, 2003, EDITORIALS; Pg. A25, 273 words

NP22 Ontario: Police seek Bangladeshi man with TB
September 7, 2004, CANADA; Pg.A5, 75 words

NP23 TB scare after drug trials: 11 workers test positive
March 9, 2006, CANADA; Pg. A8, 555 words, David Evans

NP24 Immigrants flowing in with dormant TB: report: Call for targeted testing
March 30, 2006, NEWS; Pg. A1, 750 words, Tom Blackwell

NP25 Indian doctor suspected of faking health records; Ill Immigrants
July 24, 2007, CANADA; Pg. A8, 482 words, Chad Skelton

The Montreal Gazette

MG1 Weary Kosovar refugees arrive in Canada
May 05, 1999, News; A1 / Front, 1020 words, DEREK MCNAUGHTON, DAVID GAMBLE and PAUL CHERRY

MG2 Newcomers present many problems
May 19, 1999, News; A2, 368 words, JEFF HEINRICH

MG3 Diseases are being imported - experts: Health-care professionals say many newcomers to Canada from outside North America or western Europe arrive sick or unvaccinated, a drain on precious resources.
May 19, 1999, News; A1 / FRONT, 1421 words, JEFF HEINRICH

MG4 TB vaccine losing effect: researcher: McGill doctor says he has discovered why TB isn't conquered by medicine
May 28, 1999, News; A5, 586 words, JEFF HEINRICH

MG5 90 smuggled refugees found on ship: Asians discovered crammed in hold of cargo vessel off the west coast of Vancouver Island
July 21, 1999, News; A8, 576 words

MG6 Ottawa is a sucker for sad stories, and Canadians are paying the tab
September 12, 1999, Editorial / Op-ed; A9, 760 words, DIANE FRANCIS

MG7 Kosovo flights' attendants got TB
September 28, 1999, News; A10, 130 words

MG8 Compassion isn't naivete: Francis's view of Tibetan refugee-claimants is insulting and wrong
September 20, 1999, Editorial / Op-ed; B3, 1095 words, BRIAN J. GIVEN

MG9 Troops, but not all civilians, were immunized against TB
September 29, 1999, News; A9, 575 words, JIM BRONSKILL, MIKE BLANCHFIELD

MG10 Screening of immigrants out of date
April 12, 2000, Wednesday, News; A12, 417 words, JANICE TIBBETTS

MG11 TB tests not always conclusive
April 26, 2000, Wednesday, FINAL, Living; F5, 700 words, ALLEN DOUMA

MG12 Cold Lake base is free of TB, military says
May 10, 2000, Wednesday, FINAL, News; F11, 262 words

MG13 Fund needed to fight TB
June 16, 2000, Friday, FINAL, Editorial / Op-ed; B2, 264 words

MG14 Immigrants' health poorly monitored: Report
June 26, 2000, Monday, FINAL, News; A9, 718 words, DENE MOORE

MG15 TB carrier threat to public, MDs say: Court asked to force treatment on him
November 29, 2000 Wednesday, NEWS, 620 words, GEORGE KALOGERAKIS

MG16 Most refugees healthy
December 1, 2000 Friday, NEWS, 263 words

MG17 One last chance: It's pills or jail, man with TB told
December 1, 2000 Friday, NEWS,, 1005 words, GEORGE KALOGERAKIS

MG18 Campaign over, now it's nasty: A roundup of the events, big and small, that made news this week
December 2, 2000 Saturday, THE REVIEW, 2037 words, JANET BAGNALL

MG19 TB carrier spared jail: Peruvian who defied health authorities vows to take medication
December 5, 2000 Tuesday, NEWS, 409 words, GEORGE KALOGERAKIS

MG20 Contagious man not detected
December 5, 2000 Tuesday, NEWS, 336 words

MG21 Man with deadly TB sues Canada for letting him in
December 29, 2000 Friday, NEWS, 353 words

MG22 Globalization of disease is overlooked
March 6, 2001 Tuesday, EDITORIAL / OP-ED, 319 words

MG23 Canada must remain at forefront of TB fight
March 20, 2002 Wednesday, Editorial / Op-ed; Pg. B2, 280 words

MG24 TB infects 5 at Lacolle
July 13, 2002 Saturday, News; In Brief; Pg. A4, 113 words

MG25 TB tests for immigrants could save millions: study
December 5, 2002 Thursday, News; Pg. A17, 159 words

MG26 Immigrants with inactive TB aren't told they have disease: Auditor-General's report. Sufferers informed by Immigration Canada only if they apply for study or work permit
May 28, 2003 Wednesday, News; Pg. A12, 562 words, ELIZABETH THOMPSON

MG27 Claimants kept in dark about TB
May 28, 2003 Wednesday, News; In Focus; Pg. A1 / FRONT, 73 words

MG28 Man with TB may have infected 20 during drug trial: 11 employees, 9 participants have latent form Experiment conducted at Montreal unit of U.S. company
March 9, 2006 Thursday, BUSINESS; Pg. B4, 519 words, DAVID EVANS

MG29 TB still scourge for poor, homeless: experts: Refugees, First Nations also suffer. 10 per cent of Toronto population probably infected, university director says
March 25, 2006 Saturday, NEWS; Pg. A20, 583 words, SUE BAILEY

MG30 Drug tester ordered to demolish 350-bed unit
May 19, 2006 Friday, BUSINESS; Pg. B1, 557 words, DAVID EVANS

MG31 A pandemic threatens; A strain of TB that is highly drug resistant has been found in 37 countries
May 13, 2007 Sunday, INSIGHT; Pg. A12, 659 words, PETER FINN; ANNE SUTHERLAND

The Vancouver Sun

VS1 Refugee claimant infected Vancouver doctor with TB
January 8, 1999, NEWS, A8, 591 words, Janet Steffenhagen

VS2 420 SFU students urged to get TB test after one case found to be infectious
January 13, 1999, NEWS, B1, 718 words, Chad Skelton

VS3 Treat refugees. Don't bar them.
January 14, 1999, EDITORIAL, A14, 193 words, Maureen Bayless

VS4 Racism clouds the immigration debate
September 13, 1999, EDITORIAL, 141 words, H.D. Rogers

VS5 Public health: Crew contracted TB after Kosovar flight
September 28, 1999, NEWS, A10, 112 words

VS6 Kosovars: Red Cross says volunteer warned of health hazards
September 29, 1999, NEWS, A8, 173 words

VS7 Travellers to exotic locations bring back more than souvenirs: Cases of mosquito-carried malaria have been rising so quickly Canada customs forms now have a special warning
February 26, 2000, TRAVEL, J13, 651 words, Daphne Bramham

VS8 Immigration system 'vulnerable to abuse': Auditor-general Denis Desautels finds that Canadians are not being protected and urgent action is needed to address the country's cash-strapped and ill-managed foreign offices
April 12, 2000, NEWS, A7, 785 words, Janice Tibbetts

VS9 One of four most pernicious killers is being ignored: Effective treatments exist, but TB remains a threat to millions. Canada should play a role in fighting it
May 16, 2000, EDITORIAL, A17, 703 words, R.C. Dickson

VS10 Dozens may be infected with deadly strain of TB
December 5, 2000, NEWS, A4, 246 words

VS11 Prudent policy on disease
December 5, 2000, EDITORIAL, A14, 407 words

VS12 Immigrant with TB sues Canada for letting him in
December 29, 2000, NEWS, A2, 208 words

VS13 Canada boosts immigration: The number of immigrants admitted last year brings the Liberals closer to an election promise
January 20, 2001, NEWS, A9, 536 words, Nahlah Ayed

VS14 Illegal immigrants seek refugee status: A publication ban was placed on the names of 35 claimants
April 18, 2001, NEWS, B3, 393 words, Brian Morton

VS15 TB is in control, not us: Although TB is preventable, two million people will die from it worldwide this year. Canadians, who dare not be complacent, have to contribute more to international efforts to combat the disease that can be spread by a sneeze
October 28, 2002, EDITORIAL, A15, 856 words, Bob Dickson; Alexander Soucy

VS16 TB cases rise by 35 percent in B.C.: Province's TB infection rate double the national average
November 21, 2002, NEWS; A5, 538 words, Pamela Fayerman

VS17 Immigrant TB tests could save millions: study. Medical journal urges screening, treating new arrivals for latent TB
December 5, 2002, NEWS; B5, 640 words, Pamela Fayerman

VS18 Shoddy training, poor tracking top border flaws, auditor says. Steps have been taken since 9-11 but verification lacking, report shows
May 28, 2003, NEWS; A7, 522 words, Jim Bronskill

VS19 Women 'lose health' in Canada: Women tend to take on the bad habits of the majority, report finds
October 1, 2003, NEWS, A17, 583 words, Kate Jaimer

VS20 Indian doctor accused of faking medical records for seriously ill immigrants
July 24, 2007, NEWS; A1, 674 words, Chad Skelton

The Edmonton Journal

EJ1 Drug resistant TB a threat worldwide, expert says. Immigration posses risk to developed countries
February 29, 2000, WORLD, A13, 450 words, Andy Ogle

EJ2 Drug resistant TB could threaten even First World countries. WHO warns countries must act to control disease
March 24, 2000, WORLD, A4, 607 words, Andy Ogle

EJ3 Military refutes claim of TB cases at Cold Lake
May 10, 2000, ALBERTA, A7, 374 words, Jim Farrell

EJ4 A disease that refuses to die: Stubborn scourge. Many Canadians believe that TB had been eradicated, but the disease is making comeback, killing 8,000 people a day around the world – and claiming lives in our own backyard
May 21, 2000, SUNDAY READER, 1701 words, Elizabeth Payne

EJ5 Court grants scofflaw with TB reprieve: Ordered to take medication, make meetings or risk jail
December 1, 2000, CANADA, A6, 368 words

EJ6 Man with deadly TB infects 35
December 5, 2000, CANADA, A14, 116 words

EJ7 TB sufferer trades jail threat for treatment
December 5, 2000, CANADA, A6, 240 words

EJ8 TB rises again
December 7, 2000, OPINION, A18, 321 words

EJ9 TB infected immigrant sues gov't over misdiagnosis: Up to 1,500 people exposed may also join $500M lawsuit
December 29, 2000, CANADA, A5, 550 words

EJ10 Curing Third-World diseases is in the First World's best interest: Diseases of poverty such as TB don't respect borders
February 10, 2001, TOP COPY, A3, 568 words, Andy Ogle

EJ11 Immigration is key to the future
March 15, 2001, OPINION, A18, 615 words

EJ12 Rise in TB 'tip of the iceberg,' specialist says. TB.
March 24, 2001, CITY, B3, 509 words, Bob Gilmour

EJ13 TB on the rise worldwide
March 24, 2001, LETTERS, A17, 720 words, Bob Dickson

EJ14 TB monitoring is inadequate
May 6, 2002, OPINION, A14, 178 words

EJ15 Refugee claimant infects border staff with TB
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EJ18 Drop in TB rates no reason to relax: doctor. Strains in immigrants drug resistant
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