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Do Not Disturb/Please Clean Room: The Invisible Work and Real Pain of Hotel Housekeepers in the GTA

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DO NOT DISTURB/PLEASE CLEAN ROOM: THE INVISIBLE WORK AND REAL PAIN
OF HOTEL HOUSEKEEPERS IN THE GTA

by

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in the Program of
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ABSTRACT

The hotel industry in the GTA is dependant on cheap, racialized and gendered work; the result has been significant poor health outcomes for immigrant women of colour who are over represented in this industry. This paper explores the larger structural processes intensified by neoliberal globalism that leads to the racialized segregated labour of immigrant women of colour working as hotel housekeepers. This will begin by critically analyzing the organization of the economy and the “global city” through a feminist political economy approach and by linking the downward trajectory in immigrant health to the Healthy Immigrant Effect and gaps in the Population Health Approach. This will be highlighted by personal narratives from immigrant women of colour currently working as housekeepers in the GTA, who have shared their stories and how they are actively contesting and negotiating with their spaces of precarious employment to promote and increase health and well being at work, in their homes and within their communities.

Keywords: Hotel Housekeepers; Racialized Work; Precarious Work and Health; Healthy Immigrant Effect

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INTRODUCTION

Immigrant women of colour make up the majority of labourers working in the hotel industry in North America. They are disadvantaged within this industry through processes that are dependant on cheap, racialized and gendered work; the unfortunate result has been significant poor health outcomes for the majority of women working within this industry. There are 1.3 million hotel workers in the United States and 280,000 in Canada, of whom, approximately one quarter are housekeepers (UNITE HERE, 2006). In the Greater Toronto Area 30,000 people are working in the hotel industry and the statistics show that 70 percent of them are immigrants (Verma et al., 2006). The hotel industry and the allocation of “dirty work”, cleaning and laundry, is segmented along lines of race and gender. A staggering 93 percent of cleaning and laundry staff are immigrants, 82 percent are visible minorities and 80 percent are women (Verma et al., 2006, Keung, 2007). Labeled by many as the “settlement sector”; Toronto area hotels gain the attention of many low and high-skilled newcomers who are desperate for work. Those who are highly skilled and possess foreign credentials often remain in jobs they are overqualified for in the hotel industry. Furthermore, regardless of skill, race, gender and language remain barriers to advancement and mobility both within and out of the sector (Verma et al., 2006).

Housekeepers (also known as room attendants) and hotel laundry workers are among the lowest wage earners, the median wage for a Toronto hotel worker is \$26,000 per year. In 2004, hotel worker earnings fell short of the Toronto low-income cut off of \$34,572 for a family of four (Verma et al., 2006). Toronto hotel workers are part of an increasing number of approximately 900,000 working poor in Ontario. A living wage would allow hotel workers to raise their families free from poverty and its corresponding outcomes. This would entail wages and benefit packages that reflect the cost of living in the GTA and take into consideration that

the municipalities included in the GTA are some of the most expensive cities in the world to live and raise a family. Poor wages are unfortunately just one piece of this struggle; hotel housekeeping work-related injuries are also on the increase.

The UNITE HERE¹ (2006) report entitled “Creating Luxury, Enduring Pain: How Hotel Work is Hurting Housekeepers” utilizes the first comprehensive analysis of employer records of worker injuries, including records of the major five hotel companies across North America. The analysis covers seven years (1999-2005) and 87 hotel properties with approximately 40,000 hotel employees both in the United States and Canada. They reported that 91 percent of 600 housekeepers surveyed both in Canada and the United States say they suffer from work-related pain. In addition, several other recent studies make the connection between hotel housekeeping and workplace strain and injury (Scherzer, Rugulies & Krause, 2005; Seifert & Messing, 2006; Zuberi, 2007; Lee & Krause, 2002). There is also a growing body of literature looking at the precarious nature of work and related impacts on health (Lewchuck, De Wolff, King & Polanyi, 2006; Siddiqui, 2006).

Given the overwhelming statistics presented thus far, this is an area in need of further research and analysis which is one of the major goals of this research paper. Furthermore, with this sector being highly dominated by immigrant workers, it is vital to question some the larger structural processes intensified by neoliberal globalism that leads to the racialized, segregated labour for immigrant women of colour working as hotel housekeepers and explore poor health outcomes in relation to these structures. This research paper aims to explore this further through several integrated qualitative methods ranging from oral (semi-structured interviews, narratives),

¹ UNITE HERE is a progressive labour union, representing approximately 450,000 workers in the distribution centre, retail, manufacturing, hotel, restaurant, textile, laundry, gaming and food service industries across North America. These industries employ large numbers of immigrant women of colour and UNITE HERE is committed to raising the standard of living for these workers who do some of the most “invisible” work in North America (unitehere.ca, 2008).

textual (news articles, academic studies, task force reports) to participatory methods (participant observation at a workers rally). By taking an integrated approach, I hope to capture more details and fill in the gaps highlighted throughout the literature review.

This paper will begin by critically analyzing the organization of the economy and the city through a feminist political economy approach; which looks at the racialized and gendered division of labour and how that reproduces and transforms racial and social hierarchies. Immigrant women of colour are relegated into precarious work and underemployment, which in turn has led to significant impacts on their health and well being. This downward trajectory in immigrant health will be linked to the Healthy Immigrant Effect² and gaps in the Population Health Approach³. This will be further highlighted by personal narratives from immigrant women of colour currently working in the hotel industry in the GTA, who have shared their stories and experiences. Lastly, this paper will look at the ways in which immigrant women of colour are actively contesting and negotiating with their spaces of underemployment to promote and increase health and well being at work, in their homes and within their communities. It should be noted that the term “immigrant women of colour” while ambiguous and homogenizing in essence, is used to refer to their common experience within the labour market and to make the clear distinction between the experiences between racialized and non-racialized women. Furthermore, it is important to recognize that the term “immigrant” woman is not necessarily being used in the legal, technical sense but rather to express the common day use of the word to refer to people who are seen as immigrants because of the colour of their skin, regardless of their citizenship or years of residence in Canada (Man, 2004).

² The Healthy Immigrant Effect is an observed time path showing that the initial health of immigrants is better than the native-born population but continually depletes with time lived in a new country (Newbold & Danforth, 2003).

³ Population Health is concerned with the living and working environments that affect people's health, the conditions that enable and support people in making healthy choices, and the services that promote and maintain health. It is concerned with aggregate rather than individual health status and risk factors (Public Health Agency of Canada, 2007).

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Throughout this literature review I will be making distinct linkages between structural processes of the global political economy, racialized gendered labour and the impact on the health and well being of immigrant women of colour in Canada. This paper uses a feminist political economy approach that focuses on labour market inequalities, including ethnic and gender segmentation, and the marginalization of racialized immigrants. This approach, with its focus on socioeconomic status and the material circumstances of everyday life, connects well to an understanding of the health status of immigrants. It is also consistent with a Social Determinants of Health Approach⁴; which shifts views on health status from individual behaviour to group experiences, including the processes of immigration and settlement (Dyck, 2004).

It is important to identify the limitations of using feminist political economy theory. The theory has the tendency to focus on the marginalization of immigrant women of colour and the resulting constraints on their health and health seeking behaviours, which then tends to gloss over agency (Dyck, 2004). Many studies show that women are not simply passive victims in these processes, but are contesting and negotiating their places of underemployment through collective action, union formation and networking (Siddiqui and Maitra, 2005; Messing & de Grosbois, 2001; Egan & Gardner, 2005; Noh & Kaspar, 2003; Das Gupta, 2006; Schenk, 2006; Tufts, 2006). Knowing the limitations of this approach, my goal is to explore, engage and incorporate this aspect of women's resiliency and agency into this paper by hearing from hotel

⁴ Social Determinants of Health are the social conditions in which people live and work and how that influences the health of individuals and communities. They determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment (Public Health Agency of Canada, 2007).

housekeepers directly about their experiences working in this industry and by participating in organized resistance as a way to observe and support their efforts.

Housekeeping in the Global City

“Global cities” are defined by Sassen (2006) as the sites for the key functions and resources for the management and coordination of global economic processes. The growth of these activities has in turn produced a sharp growth in the demand for highly paid professionals. Both the firms and the lifestyles of these professionals generate a demand for low-paid service workers. Global cities are also sites for the incorporation of large numbers of low paid women and immigrants into the service sectors (Sassen, 2006). This integration occurs through the demand for service workers and indirectly through the consumption practices of high-income professionals, which in turn generates a demand for maids, cleaners and nannies as well as low-wage workers in expensive restaurants, retail and hotels.

As the global city seeks to attract tourists and investors, it depends greatly on the hotel industry to support these capitalist ventures. However, the hotel industry is also competing for a piece of this capitalist pie as they develop economies of scale as way to benefit their bottom line (Seifert & Messing, 2006). They attract a diverse range of clientele, as well as organizers, participants and frequenters of conventions, conferences, tradeshowes and weddings; who at the end of the day need a place to kick up their feet and rest their weary heads.

In the GTA, the hotel industry consists of approximately 183 hotels which translates into 35,865 guest rooms ranging from luxury and upscale (53 hotels with 18,382 rooms) to all-suites, mid-scale and limited service (129 hotels with 17,483 rooms) (Verma et al., 2006, p. 4). These hotels generate significant financial impacts for the global city in terms of employment, business

and government income. A study by PKF Consulting which was published in a recent report entitled “An Industry at a Crossroads: A High Road Economic Vision for Toronto Hotels” conducted by Verma et al. (2006, p.4) also known as the Toronto Task Force on the Hotel Industry, estimated that in 2005 the GTA hotel industry generated:

- Overall value-added impacts of \$2.2 billion of direct spending. Of this amount, close to \$2.0 billion was attributed to operating business expenditures and \$194 million to capital expenditures.
- An estimated \$1.64 billion share of the GDP for Ontario with \$1.54 billion in Greater Toronto.
- 30,776 full-year-equivalent jobs, about 0.85 per hotel room.
- Total wages and salaries totaling \$666 million, of which the total hotel payroll amounted to \$518 million.
- \$682 million in tax revenue (\$332 million in federal taxes, \$252 million in provincial taxes and \$97 million in municipal taxes).
- A net operating income of \$310 million, or \$8,653 per available room.

As the hotel industry and the global city competitively respond to globalization and reap the financial benefits, the costs of production must be extracted from somewhere, and the intensification of this work must also be allotted to a group that can keep the costs significantly low. Using critical race theory one can connect the racial domination under colonialism to current day capitalism to explain the racialized division of labour⁵ in the hotel industry as there are substantial grounds to link the production of racial categories to the reproduction of cheap labour (Bolaria & Li, 1988). This is reflective in the low wages and lack of benefits earned by hotel workers and as a mirrored in a broader system of discrimination based on race and gender.

Historically, slavery and indentured labour existed because there was a social and economic system that justified race as a necessary means of procuring free and cheap labour. The

⁵ Also known as the “division of labour” which reproduces processes and ideas by consciously or unconsciously organizing particular divisions of labour based on racial, ethnic and gender stereotypes (Das Gupta, 1996, p.3).

cheaper the labour inputs are, the higher the profits. Given that the reproduction of labour power is necessary for capitalism to exist; the value of the work is unacknowledged because capitalism can only survive as long as the reproducing labour power costs less than what the labour power can produce (Giles & Arat-Koç, 1994; Bolaria & Li, 1988). The dilemma of capitalism is that while the reproduction of labour power is necessary, the capitalist goal is to create profit and thus keep the costs of reproduction low. In a feminist political economy framework, it is mainly women who take on roles of social reproduction, furthermore, it is the labour of migrant women which facilitates the entry of more “first world” women into the public sphere by liberating them from the most gendered and labour intensive aspects of social reproduction (Maher, 2004). Moreover, “race” or skin colour becomes a convenient way to assign already marginally undesirable people to undesirable jobs. Physical characteristics are paired with “dirty work” and over time, both these cultural and physical characteristics of the marginalized group becomes inseparable from its performed labour and subservient position (Bolaria & Li, 1988). Canada has not been an innocent bystander in this capitalist construction of race and gender. As a state, it has in the past and continues today to stratify labour in terms of race, while giving the impression of solidarity through a multicultural rhetoric.

Bannerji (2000) suggests that the Canadian state has played a significant role in creating a labour market that assists in the regulation and exploitation of racialized labourers. Canada has long been dependant on imported labour and has thus organized the labour market along lines of “race” and gender; locking racialized immigrant workers into spaces of menial labour and poor wages. And as such, racialized people are more likely to be underemployed than those of European backgrounds; as well, racialized workers are most likely to be in low-status, precarious work situations. Numerous studies show that homeworkers, piecemeal workers, cleaners and

domestics, largely represented by immigrant women of colour, occupy the worst positions among marginalized labour groups (Bannerji, 2000; Das Gupta, 1996; Giles & Arat-Koc, 1994).

This type of work abounds in the “global city” a term coined by Sassen (2006) who explains that socio-economic hierarchies emerge within the “global city”. At the top of the hierarchy are high-tech and service professionals who are engaged in conspicuous consumption, thus creating a need for low-wage labourers (Sassen, 2006). Sassen describes the gendering and devaluing of “female type jobs” based on a notion of “valorization and de-valorization” of women’s labour. She explains there is marked racialization of labour market segmentation which has placed female immigrants in manual, low paying work (Sassen, 1998). The process is one that valorizes and over-valorizes certain types of outputs, workers, firms and sectors while de-valorizing others (Sassen, 1998). Sassen describes how this is part of a larger globalizing process of the demographic transformations evident in large cities. These global cities attract migrant women in desperate need of employment and then exploit their labour. The global city heightens the marginalization of women and immigrants who are exploited and employed for low wages to serve “high-tech professionals”. The current dominant narrative of globalization is the emphasis placed on “upper circuits of global capital” that valorizes highly educated professionals (Sassen, 2006). In turn, this process has carved out spaces for low-waged labour where immigrant women are strategically incorporated into the economic system. Low-wage workers get incorporated into the leading sectors, but they do so under conditions that renders them and their poor working conditions invisible.

Man (2004) describes that neoliberal restructuring, such as privatization, deregulation, government downloading and budget cuts to social welfare programs has intensified these conditions greatly since the 1980s and has served to marginalize immigrant woman of colour.

She argues that the dismantling of social support programs and the segmented labour market has undermined immigrants' ability to integrate into the receiving society and as such are more susceptible to social exclusion. Moreover, immigrant women of colour are used within this restructuring process to be flexible, disposable labour, leaving them with no benefits or job security, which is suited to meet the needs of the globalized economy (Man, 2004, p.137). Similarly, Cheng (1999) describes how gender ideology has functioned and been utilized by the state within the global capitalist system to structure migration and shape the labour market. Gender ideology shapes the differential experiences of male and female migrants in terms of what employment they are channeled into and allotted. Cheng points out that this gender ideology is further compounded by race. For instance, women of colour are traditionally essentialized into roles that dominate the service sector and domestic labour. They are allotted positions that require submission, dexterity, nimble fingers and attention to detail. Women are naturally perceived to be caring and nurturing because of their reproductive capacity (Cheng, 1999). Hotel housekeepers provide the labour that shapes hotels as major sites of social reproduction (Giles, 1994). The term "social reproduction" or "reproductive labour" refers to the activities and processes by which human beings are directly or indirectly sustained materially and psychologically (Sehgal, 2005). They are practices that are rooted in historically specific social structures and gender ideologies that are reproduced at the state, community and family level (Chang, 2000).

Hotels are in the business of creating profits from this social structure as they recreate the "home-away-from-home" as a space of rest and relaxation (Sherman, 2007). Some go further to provide luxury accommodations and increased amenities that include heavy mattresses and luxury linens. The upgrading of rooms is a trend across North American and international hotel

chains where you can now find plush towels, bath robes, in-room coffee service stations and thicker mattresses. For example, the Hilton hotel has introduced a king size “Serenity Bed” that includes 18 features: pillow top mattress, mattress topper or featherbed, three sheets, down blanket, down duvet insert and cover, two standard pillows and cases, two king sized pillows and cases and decorative bolster pillow and case. The mattress is 12.5” thick and weighs 113 pounds and the linens for each bed weigh 19 pounds (UNITE HERE, 2006, p. 12).

A housekeeper who changes one Serenity Bed™ per room and cleans fifteen rooms per day strips over 500 pounds of soiled linen and replaces it with 500 pounds of clean linen. Further, the sheets and blankets are tucked under the mattress requiring the housekeeper to lift the heavy mattress at least eight times in the course of making a single bed (UNITE HERE, 2006, p. 12).

Housekeepers often have to change multiple beds like sofa beds and roll-away-cots and some clean more than 15 rooms a day, ergo, the average workload can be more than described in the above scenario (Lee & Krause, 2002).

The significance of the “Serenity Bed” has much more meaning than simply a comfy night’s sleep; it positions guests in a place of entitlement to recast their desires as needs, to consume the unlimited labour of others (Sherman, 2007). It exists within a larger global city structure of unequal allocation of resources because the consumers can afford it, and the low-waged service worker cannot. The reproductive labour housekeepers are expected to produce and maintain in these hotel rooms has increased significantly in workload and physical demand. The amount of work per hotel room and the pace in which the work is done exceeds the previous workloads of years past, which makes hotel housekeeping significantly more dangerous for health. While these changes, up grades and additional amenities in hotel rooms add to the customers’ overall experience, not to mention the corporation’s bottom line; they have significant poor outcomes on the health and well being of the housekeepers who are literally

breaking their backs to maintain the whims of consumers and the demands of the capitalists in the global city.

Watch Your Back! Working Conditions and Health

Some days my leg would swell up and I would literally limp from room to room. When the pain was at its worst, I would sit on the beds and cry because it hurt so much. Valesie McCaskill hotel housekeeper at the Chicago Hilton Towers (UNITE HERE, 2006, p. 3).

The overwhelming majority of hotel housekeepers cope with persistent pain on the job according to findings in the UNITE HERE (2006) study “Creating Luxury, Enduring Pain: How Hotel Work is Hurting Housekeepers. In 2005, 600 UNITE HERE represented housekeepers were surveyed about workplace pain. The survey took place in several cities across North America, including Los Angeles, Boston and Toronto. The results were shocking; 91 percent reported physical pain associated with their work as hotel housekeepers. Of those with pain, 86 percent reported that their pain started after initially being hired as a housekeeper. The survey also determined that 77 percent said that pain interferes with routine activities and that 66 percent took pain medication regularly (UNITE HERE, 2006, p. 7). For many, this statistical data can be hard to make sense of partly because of the overwhelming statistics, but that is significantly due to the invisibility of housekeeping work and the racialized body this pain is inscribed on.

The Canadian Centre for Occupational Safety and Health (CCOSH), the federal government’s primary information centre on workplace safety, reports that a hotel housekeeper changes body position every 3 seconds while cleaning a room. If one assumes that the average cleaning time for each room is 25 minutes, it can then be estimated that a housekeeper assumes 8000 different body postures every shift (UNITE HERE, 2006, p. 6). Furthermore, housekeeping

is a physically demanding job, forceful movements while using awkward body positions like lifting mattresses, cleaning tiles and vacuuming every shift can be very hard on the body. Hotel workers are 48 percent more prone to be injured on the job, than a typical worker in the service sector. They also have higher rates of serious, disabling injuries that often require days off or reassignment. These disabling injuries occur to hotel workers at a rate 51 percent higher than for service sector workers in general (UNITE HERE, 2006, p. 3). In Canada, the British Columbia Workers Compensation Board found that among hotel workers, overexertion was responsible for 27 percent of Worker Compensation claims. It also found that housekeepers accounted for 39 percent of overexertion cases, more than any other job title (UNITE HERE, 2006). This can be attributed to the vulnerable and poor working situations, leaving housekeepers with not much control over their hours and schedules.

One of the contributing factors of pain and injury in the workplace is the standard way management organizes housekeeping duties and work. It is based on a “room quota” system where housekeepers are required to clean a certain number of rooms per shift. The more rooms, the faster they must work. The common complaint about the quota system is that housekeepers do not know what condition the room will be in prior to entering. There are horror stories of messy parties and vandalism that leave guest rooms in terrible condition. Housekeepers are still responsible to clean these rooms in addition to their “standard” work day. There used to be “hotel housemen” available for these types of situations and more. Housemen were critical to helping housekeepers with the onerous and heavy tasks such as stripping beds, moving cots, rolling away beds and cribs but this position in the hotel industry has been significantly cut and reassigned to the workers that remain (UNITE HERE, 2006). Hotel managers have given the housemen’s work to housekeepers in addition to their everyday duties. Employment data shows

that the number of housemen employed relative to housekeepers from 1999 to 2003 has been significantly reduced. In 1999 there were approximately 18 housemen per 100 housekeepers. Four years later the number of housemen per 100 housekeepers fell to 12, a drop of 33 percent (UNITE HERE, 2006, p. 13).

Table 1 depicts some of the basic work tasks needed to be completed per room by a housekeeper but these can vary, as mentioned, depending on the room condition. The problem continues to escalate as hotel companies compete in the global market and implement room changes like heavier luxury beds and duvets, triple sheets, extra pillows and in-room amenities like treadmills. Coupled with the intensity of time and pressure; housekeepers report that they must race against the clock to get their work done which means skipping meals, breaks and rests

Table 1
Basic Hotel Housekeeper Tasks

Bedroom Tasks	Bathroom Tasks
• Remove all room-service items from room • Strip bed(s) of all sheets, blankets and duvets • Place bottom sheet on each bed and tuck 4-8 times • Place top sheets and blanket on each bed and tuck 4-8 times • Spread duvet on bed • Remove 4-8 pillowcases per bed and stuff pillows into fresh cases • Dust all nightstands and desk • Carefully restock and arrange pens, papers and other written materials (i.e. room service menus) Dust armoire or dresser, including behind the TV • Clean TV screen • Retrieve TV remote and rearrange TV channel guides • Pick up trash and empty bedroom's wastebasket • Wash and dry ice bucket and rearrange on counter • Collect, wash and dry dirty glasses • Dust vents • Put away all ironing boards and other equipment • Vacuum all floors	• Pick up soiled towels and place on cart • Replace soiled towels • Clean and disinfect toilet bowl • Wipe down top and side of toilet • Restock toilet paper • Wipe down counter tops • Clean sink(s) and polish faucets • Replace and arrange toiletries (i.e. shampoo, soaps) • Clean bathroom mirror • Wash and dry coffeepot and cups and rearrange on counter • Scrub inside of bathtub • Clean/replace shower curtain or scrub shower door • Clean bath and shower walls • Pick up trash and empty bathroom wastebasket • Mop floor • Dust vents

Source: UNITE HERE (2006, p. 4)

that are necessary to prevent injury. There is a significant correlation between increasingly excessive workloads and the rising rates of musculoskeletal disorders, such as low back pain, tendonitis, back and shoulder injuries, bursitis of the knee (known as Housemaid's knee), carpal tunnel syndrome and persistent neck, hand and wrist pain, which are all characteristic of hotel housekeeping work (UNITE HERE, 2006; Scherzer, Rugulies & Krause, 2005; Lee & Krause, 2002). This coupled with chronic understaffing, has pushed the workers bodies to the breaking point. The most disturbing aspect is that all of these injuries and corresponding pain associated with hotel housekeeping is preventable and treatable, but the current focus on "improving the bottom line" has diminished the attraction of investing in the long-term health and job satisfaction of workers (UNITE HERE, 2006; Seifert & Messing 2006). As competition intensifies, hotels will continue to change labour practices towards more precarious work situations and add to the amenities they offer as a way to minimize costs and to attract more high-end clients, who provide the largest profit margins. Since housekeeping is furthest from the minds of those who devise these work and marketing strategies, any changes in products and services are likely to have major unforeseen consequences for housekeeper's workloads, health and safety.

Lee and Krause (2002) conducted an interesting participatory action based research study with 258 hotel housekeepers working in various San Francisco hotels. One of their research goals was to "cut through the rumors to find out if a significant number of new duties had been added, and if so, what if any was the impact on workers health?" (p. 271). They used several methods, one of which was a mock hotel room complete with two beds, a bathtub, a sink, furniture and equipment. Volunteers were given an introductory lesson in ergonomic risk factors and then were asked to go through the typical motions of cleaning a room. While this occurred,

participants were asked to call out freeze when they noticed a risk of injury. Through this exercise researchers found that the weight and awkwardness of linen carts and vacuum cleaners, weight and size of bed spreads, placement of furniture, number of beds, and weight of mattresses were all potential sources for ergonomic stress on the body (Lee & Krause, 2002).

The researchers also investigated workload and task issues by asking the participants to list on index cards the various tasks associated with their jobs. They were then asked to identify which of those tasks created time pressures or stress, and lastly, they were asked to highlight when particular duties and tasks were introduced as a part of a room attendants job. The researchers found that when the hotels downsized and cut jobs that once supported room attendants, like utility personnel who for example would organize and pack carts for the housekeepers every evening so they would be prepared when they started their shifts in the morning; those tasks were all downloaded to the housekeepers on top of their regular jobs. In addition, the reasons for increased tasks and duties varied per hotel, even though the room quota may be the same. Some factors included travel time between floors, wings, buildings, problems with replacement linens, restocking carts, garbage and food left in rooms, extra cleaning and in-room coffee service. Therefore room quotas are not an accurate reflection of physical workload or appropriate and equal workload assignments (Lee & Krause, 2002).

The last method Lee and Krause used in this study was a large scale survey, conducted at various sites around San Francisco to encourage housekeeper participation and accessibility. Some very significant findings came out of the survey; they found that the overall health status of housekeepers appeared to be worse than the general US population. Self-rated health by the housekeepers averaged at 56 percent which is significantly lower than the general US population average of 72 percent. More than three quarters of the participants interviewed reported work-

related pain, 73 percent visited doctors and 53 percent of all cases were severe enough to take leave from work (Lee & Krause, 2002, p. 277).

Another significant finding reported that the high rates of musculoskeletal symptoms cannot be linked to an aging workforce, as is often tabled as a reason for the high injury and health depletion rates. Lee & Krause found that equally high rates of musculoskeletal symptoms occurred in both young and older housekeepers. The findings in this San Francisco study suggest a correlation between poor working conditions and reduced health outcomes for hotel housekeepers regardless of age. The participants reported increasing physical workloads and high levels of stress in conjunction with their work. The study also confirmed that housekeepers have high rates of pain and disability which corresponds with their perceived poor health average being significantly lower than the national average in the United States.

A similar study was conducted by Schezer, Rugulies & Krause (2005) in Las Vegas with five types of hotels: upscale, mid-level, all-suite, convention and older economy. They surveyed 941 unionized hotel housekeepers about work-related pain, injury, disability and reporting. They found that 3 out of 4 workers (75 percent) experienced work related pain and that it began with working in the hotel industry (94 percent). 31 percent reported their pain to management and 20 percent went forward to file for workers compensation; 35 percent of their claims were denied. The researchers went further to explore in this study the different barriers housekeepers faced when reporting and why some chose not to report. Of the 67 percent that did not report in this study their reasons ranged from “I thought it would get better”, “I didn’t know I should”, “too many steps to reporting” and fear of getting in “trouble” or “fired”. Some participants also mentioned that they believed that management simply did not care; others perceived that pain was a part of getting older and some were hesitant about losing hours at work (Schezer,

Rugulies & Krause, 2005, p. 485). This study estimated that 69 percent of medical costs were shifted from employers to workers. And that housekeepers appear to be dealing with work related pain on their own rather than risking loss of income, out-of-pocket medical expenses or backlash from employers. These barriers led to an underreporting of injuries, inadequate or delayed care, and failure to recognize and address hazardous conditions that can lead to the work-related health condition worsening and eventually becoming chronic (Schezer, Rugulies & Krause, 2005, p. 487).

While the numbers and percentages in these particular studies speak volumes, it is very important to put a name and story to the experiences and pain experienced by hotel housekeepers. Many women working in the industry are speaking up and sharing their stories as a way to bring personal experiences and lived reality to numerical statistics that can often separate the people from their narratives. The UNITE HERE (2006) report was a platform for many women's stories of work-related pain and revealed a sad story of pain at work and in the home, for instance:

Hasime Hashimi, a 37-year old housekeeper at the Allerton Crowne Plaza in Chicago, has had three different doctors tell her that the severe back and shoulder pain she suffers is a direct result of her work. She takes several medicines a day: "By the end of the day, the pain is so bad I can barely move. The doctor tells me to follow this routine when I come home after work: The first thing I take is 800mg of Ibuprofen and my cyclobenzaprine, a prescription muscle relaxer. Then I need to spend 30 to 45 minutes in a hot shower to relax my back and shoulder muscles. After that I lie down, sometimes for hours. Most days I can't cook for my two children." Last year, Hasime's doctor also prescribed her anti-stress medication because of all of the pressure she was under at work. "I feel like I have a construction job" (UNITE HERE, 2006, p.7).

Hashimi's story not only depicts the severity of pain connected to this work, but how pain does not simply exist in the space it is inflicted. Housekeepers take their pain home with them. It effects interactions with family members and children in the most intimate of ways. For example, Jade Magday is the 16-year old daughter of a housekeeper who has cleaned rooms at the

Sheraton Royal Hawaiian Hotel in Honolulu for over 24 years. Jade describes her mother's fatigue and its impact on her life:

Imagine . . . doing beds, dusting, cleaning toilets, showers, bathtubs, furniture, vacuuming and mopping all day long. I don't blame her for being tired. And she does all of this just so we can have a good life. Whenever possible, I try to help my mom. A lot of times when she gets home from work and her body aches too much I massage her shoulders and back. Whenever she's too tired to get up from the sofa or the chair I will bring things to her like her medication and water. I wish things weren't this way. There are times when I want to go shopping or just go for a walk with my mom, but she can't because she is too tired or her body aches too much (UNITE HERE, 2006, p. 11).

Little has been written about hotel housekeeper's experiences with work related pain and the corresponding effects on familial relationships within the home. However, as Magday's narrative clearly illustrates children are affected by the real pain experienced by their mother's work in the hotel industry; and one can speculate as to the strain that could potentially cause in other aspects of the workers life. This is a significant gap in the literature and is in need of further research and exploration to get a better sense of the impact on workers lives in the home and community.

The literature review will shift to link an emerging phenomenon called the "Healthy Immigrant Effect" to the current political economy discussion as a way to explore this topic in a growing body of literature on the decline of immigrant health in Canada (Noh & Kaspar, 2003; Ali, McDermott & Gravel, 2004; Dunn & Dyck, 2000; Dyck, 2004; Hyman & Guruge, 2002; McDonald & Kennedy, 2004; Newbold & Danforth, 2003; Ng, Wilkins, Gendron & Berthelot, 2007). Hyman (2007) in her recent CERIS Working Paper entitled, "Immigration and Health: Reviewing Evidence of the Healthy Immigrant Effect in Canada" points out that it is well established that employment and income are major determinants of health and that several reports suggest that recent immigrants are not catching up economically as quickly as previous immigrant cohorts. Immigrant experiences of economic strain, unemployment or underemployment may also take a toll on immigrant's health. According to Hyman this may

seriously exacerbate the Healthy Immigrant Effect and will need more investigation over time (Hyman, 2007, p. 26). Could precarious underemployment, such as hotel housekeeping, be a contributor to the decline in immigrant health in Canada?

Healthy Immigrant Effect

The Healthy Immigrant Effect is an observed time path showing that the initial health of immigrants is significantly better than that of the native-born population upon arrival; however, this continually depletes to meet or surpass that of the native-born population with “Years Since Migration” (YSM). For instance, immigrants who have lived in Canada for more than ten years experience a similar prevalence of chronic-conditions and long-term disability as the Canadian born population (Hyman & Guruge, 2002, p. 183). The Healthy Immigrant Effect has also been reported in similar “first world” receiving countries such as Australia and the United States, which both have similar point selection systems and medical health examination requirements. Researchers have linked the phenomenon to selection-immigration systems based on points that focus on employability, optimal physical and psychological health (Noh & Kaspar, 2003).

The “healthy” component to the Healthy Immigrant Effect is linked, in part, to a process of inequality and opportunity, where healthy people who are motivated and have the economic means to migrate can often do so; and those who are poor, sick or disabled have significant barriers to migrating (Hyman, 2007; Ng et al., 2007). For example, Canada’s immigration process selects the “best” immigrants on the basis of education, language, job skills and through the passing a rigorous medical health examination given by a designated medical practitioner approved by Citizenship and Immigration Canada (Hyman & Guruge, 2002; CIC, 2007; Noh &

Kaspar, 2003; Ng et al., 2007). Therefore when immigrants arrive in Canada they are in optimal health.

According to a recent Statistics Canada report entitled “Healthy Today, Healthy Tomorrow? Findings from the National Population Health Survey”, conducted by Ng et al., (2007) reported that an earlier longitudinal study using the first four cycles of the National Population Health Survey found that immigrants to Canada, European and non-European combined were at higher risk of deterioration in health than was the Canadian-born population. Their new analysis of five cycles of National Population Health Survey data, (which now distinguishes between European and non-European immigrants) shows that the difference is attributable to those from non-European countries, who were twice as likely as the Canadian-born to report deterioration in their health. For example, participants had rated their health good, very good or excellent in 1994/95, but later described themselves as being in fair or poor health. This decline was particularly pronounced among recently arrived non-European immigrants. However, even long-term non-European immigrants were more likely than the Canadian-born to report a shift toward fair or poor health (Ng et al., 2007). The results of the analysis of longitudinal data suggest that the Healthy Immigrant Effect does exist in Canada as recent non-European immigrants’ are at higher risk than the Canadian born population of reporting deterioration in their health.

At the time of arrival, many immigrants, especially refugees, lack social and material resources. The set of factors which influence the health of a population are much more problematic for immigrants, as they face considerable barriers associated with language, racism, discrimination and perceived gender roles (Newbold & Danforth, 2003). Some researchers have found that the depletion of health could potentially arise from a process of acculturation and/or

barriers in access to health services due to differences in language and culture (McDonald & Kennedy, 2004; Noh & Kaspar, 2003). Acculturation is the way in which immigrants take on characteristics and ways of life in the new country and includes the adoption of Canadian (“western”) norms for diet, smoking, drinking and sexuality (Noh & Kaspar, 2003). While others have found that racialization and poverty due to unemployment and underemployment are determinants resulting in poor health (Gastaldo, 2005; Hyman & Guruge, 2002; Egan & Gardner, 2005).

For instance, a recent study on access to health care in Ontario entitled “Immigrant, Refugee and Racial Minority Women and Health Care Needs” conducted by the Women’s Bureau of the Ontario Ministry of Health documents the health care experiences of minoritized women in Ontario (Egan & Gardner, 2005). Interviews took place in six regions: Ottawa, Thunder Bay, London, Windsor, Sudbury and Toronto. The most critical finding was that racialized immigrants and refugee women are discriminated against by the Ontario health care system. Many of the respondents observed that those who are different are seen as inferior to white, Canadian health care providers and were treated disrespectfully and in a discriminatory way (Egan & Gardner, 2005). Structural barriers were outlined by the women, including the lack of access to language training and underemployment, which restricts the time to access mainstream health care services which are primarily offered during the day. Racism, limited language, and literacy levels combined with a lack of economic opportunities inhibited the ability of respondents to use medical services, which has a significant impact on women’s health (Egan & Gardner, 2005).

Immigrant women face multiple barriers that include poverty, marginalization, gender gaps and the social forces that reinforce them like underemployment, multiple role burden, social

isolation and discrimination (Hyman & Guruge, 2002, Gastaldo, 2006). Immigrant women encounter unemployment and underemployment due to professional accreditation problems, non-transferable education, and/or language barriers (Oxman-Martinez, Abdool & Loiselle-Léonard, 2000). According to Dyck and McLaren (2004) international research on female immigrants suggests that social and economic changes linked to immigration have impacted women's work and health. Given this, do current health models in Canada address and reconcile the real health needs of immigrant women of colour? The following will give an overview of the framework for the Population Health Approach and its focus on the Social Determinants of Health, which is used as a universal standard and guide for good health in Canada; but is this standard working?

Population Health Approach and the Social Determinants of Health Critique

According to the Population Health Approach used by Health Canada, many broad determinants influence the health of all Canadians (Table 2). The analysis of the Social Determinants of Health status for human populations has led to an emerging Population Health Approach on human health. Population Health is an approach that aims to improve the health of the entire population in an effort to reduce health inequalities in various population groups (Dunn & Dyck, 2000; Public Health Agency of Canada, 2002b). In order to reach these objectives, the approach actively looks at a range of factors and conditions that have a strong influence on health, hence, what is known as the "Social Determinants of Health".

The Public Health Agency of Canada (2002b) describes that health status improves with each step up the *income and social status* hierarchy. High and sufficient incomes determine good standards of living like safe housing and nutritious food. Income is strongly linked to social status because the amount of control people have over their life circumstances, especially

Table 2
Population Health Approach: Social Determinants of Health.

1. Income and Social Status
 2. Social Support Networks
 3. Education
 4. Employment Working Conditions
 5. Social Environments
 6. Physical Environments
 7. Personal Health Practices and Coping Skills
 8. Health Child Development
 9. Biology and Genetic Endowment
 10. Health Services
 11. Gender
 12. Culture
-

Source: The Public Health Agency of Canada (2002b).

stressful situations may inhibit their ability to take action. *Social support networks* are families, friends and communities that are vital in offering support to individuals in their time of need. *Education*, equips people with “relevant” knowledge and skills for daily living and employment. *Employment and working conditions* provide economic stability and a healthy work environment is associated with good health. The *physical environment* includes factors such as air and water quality. *Personal health practices and coping skills* are essential in preventing diseases and having effective coping skills enables people to be self-reliant and handle stress better. Recent research in *biology and genetic endowment* has shed new light on "physiological make-up" as an important health determinant. *Healthy child development* has been linked to positive prenatal and early childhood experiences. Lastly, in regards to *health services*, there is a relationship between the availability of preventive and primary care services and improved health (Public Health Agency of Canada, 2002b).

The perspective claims that the major determinants of health status, especially in developed countries, are not only medical care inputs and utilization⁶, but cultural, social and economic factors. According to Dunn and Dyck (2000), the influence of these factors manifests itself social gradients of health status resulting in significant inequalities for some and advantages for others. For example, data continually shows that life expectancy increases with socioeconomic status in all developed countries. Changes in social status and differences in cultural identity between the origin and host societies are important aspects of the immigration experience and impacts greatly on the health of immigrants (Dunn & Dyck, 2000). Therefore, it is not simply enough to have a “one-size-fits-all” model for Population Health in Canada; especially when immigrant’s social determinants of health are compounded and intersectional, leaving them more vulnerable than the rest of the population, as clearly seen in the circumstance of hotel housekeepers and their precarious work situations.

Precarious Work and Health

Hotel housekeeping and cleaning work in general has shifted significantly towards precarious work. In Canada, this shift towards precarious or contingent work, as it is also known, began in the early 1980s; and was and continues to be exacerbated by neoliberalism (Schenk, 2006; Herod & Aguiar, 2006; Seifert & Messing, 2006). Precarious employment includes forms of work involving limited social benefits and statutory entitlements, job insecurity, low wages and high risk of ill-health (Vosko, 2006; Lewchuck, De Wolff, King & Polanyi, 2006; Martens Nijhuis, Van Boxtel & Knottnerus, 1999). It is shaped by employment status, various forms of employment (temporary, seasonal, part-time) and dimensions of labour market insecurity (SARS

⁶ Utilization is commonly examined in terms of patterns or rates of use of health care services such as hospital care, physician visits, and specialists (Ali, McDermott & Gravel, 2004).

for example, hit the hotel industry very hard in the summer of 2003); as well as social context (what type of industry, full-service, luxury) and social location (gender, race/ethnicity).

Teelucksingh and Galabuzi (2005) have expanded the discussion on social location significantly in their work entitled “Working Precariously: The Impact of Race and Immigrants Status on Employment Opportunities and Outcomes in Canada”. They argue that racial discrimination is experienced among racialized workers in the Canadian labour market, and as the demographics of the Canadian population continues to change with immigration and globalization, these trends are likely to continue. Their findings show that the labour market is segmented along racial lines, with racialized groups showing an over-representation in precarious low paying employment and an under-representation in well paying, secure employment. For example, racialized persons make up 46 percent of workers in the sewing, textile and fabric industries, over 36 percent of taxi and limo drivers, and 42 percent of electronic assemblers. However, racialized workers make up only 3 percent of executives and 1.7 percent of directors on boards and organizations (Teelucksingh & Galabuzi, 2005, p. 4). Racialized workers are clearly over represented in precarious type work and the impacts on health and well being is very important to future research in this area.

Seifert and Messing (2006) conducted research in Montréal, Canada to analyze how work intensification associated with neoliberalism impacts housekeepers in two Montréal hotels. The results showed that precariousness associated with neoliberal globalism, such as depletion in hours, outsourcing, restructured tasks, added amenities, and the standardization and upscaling of hotel furnishings, has intensified work and reduced housekeeper’s ability to regulate their workload. The intensification of time and a growing precariousness of work have also caused social problems among housekeepers. They found that the growing precariousness of work in the

industry encourages workers to compete with each other for “favours” from management who allocate work and hours, an outcome which increases the power held over them by their employers (Seifert & Messing, 2006).

Historically, hotel cleaning in Montréal was dominated by white, Canadian-born workers, who enjoyed stable, employment longevity. As globalization has impacted migration and work patterns, the demographic of housekeepers has become much more diverse in this city.

Housekeepers in Montréal comprise a complex diversity of working class white women and educated immigrants, many who work on a contingent basis (part-time, temporary, and/or sub-contracted). This has resulted in dynamics of race and class solidarity, as well as conflicts with hotel housekeepers. Seifert and Messing observed that racial/ethnic alliances are used both to regulate workload and defend group members against perceived injustice. They found the same to be true around class consciousness. However, there are obvious multidimensional divisions between “Canadians” and “Immigrants”, “regular cleaners” and “students” and between senior housekeepers and those with less seniority (Seifert & Messing, 2006, p. 561). These rifts cause rivalries that reduce solidarity among workers and greatly works in favour of hotel management. While race, ethnicity, class and seniority conflicts are not new to this labour market, they are however intensified by the push towards the flexibilization of work, financial insecurity and the exacerbation of the differences in employment status.

Furthermore, neoliberal ideologies tend not to support labour unionism and workers rights. A shift toward precarious work and privatization has resulted in low paid workers without health benefits or safety nets (Zaman, 2006; Herod & Aguiar, 2006). Without health benefits one can not easily afford prescription drugs, dental check-ups, specialized care or alternative health services such as chiropractic care, massage therapy or naturopathy. Statistics show that less than

half of non-union workers have access to medical, dental and disability coverage in Canada (Public Health Agency of Canada, 2002a). Overall, workers who belong to unions have better working conditions, including wages than those who are non-unionized (UNITE HERE, 2006; Das Gupta, 2006; Zuberi, 2007). Many employees at the unionized hotel branches in Zuberi's (2007) study were positive about working in a union job and described the union benefits as a safety net, with concrete programs and benefit packages.

Union membership provides important advantages in light of the shift towards precarious employment, like perceived job security, better benefits, wages and working conditions for the workers. I plan to explore this further in my study to see how immigrant women of colour working as hotel housekeepers in the GTA perceive their health and well being in relation to working in a unionized hotel environment. While the literature and statistics do show that unionized workers are better off, does that actually translate into good health and well being both in and outside of the workplace? Or are there significant barriers being missed in this literature, given that hotel housekeepers in the GTA are experiencing such high rates of work related pain?

RACE, WORK AND HEALTH: METHODS AND FINDINGS

My goal when I initially started this work was to research my topic exclusively through Participatory Action Research (PAR). PAR is applied research that treats knowledge as a form of power and seeks to collaborate with those affected by the issues being studied, which purposefully removes the line between research and social action. Those who are being studied participate in the research process as a way to balance power relations (Neuman, 2006). PAR defines the researcher's goal as advancing a cause or improving conditions by expanding awareness. It assumes that ordinary people can become aware of conditions and learn to take actions that can bring about improvement; therefore the research "subjects" are the greatest bearers of knowledge and experience.

I have stayed close to this philosophy in the ways I have designed and executed this study. However, given the time restraints of this one year intensive masters program, complete with a full course load and a field placement component, it was simply not feasible to engage fully with PAR because it is a time intensive research method in comparison with other methodologies that do not consult, collaborate or engage with the participants involved throughout the process. Hay (2005) acknowledges that a researcher can make their research more participatory by adopting various elements of PAR into their work. While I could not engage fully with PAR, I still actively integrated various strategies that promoted reciprocal relationships of co-learning; that was mindful of respecting the participants' time, knowledge and experiences. The study ended up being a small scale qualitative venture that used several integrated methods from oral (semi-structured interviews, narratives), textual (news articles, academic studies, task force reports) to participatory methods (participant observation at a workers rally).

In conjunction with time restraint issues, another obstacle I experienced was the lengthy time it took to get ethics approval for this study. Again, given this is a one year program, time is very precious, and even if you anticipate turn-around-time, you can never be sure of what roadblocks may arise in the ethics review process. Hay (2005) points out that while ethical rules and ethics committees are very important to research, they are not unproblematic. For instance, rigid codes cannot always deal with the variability and unpredictability of research. What may be appropriate in one situation may not be appropriate in another. The blanket application of rules does not consider individual circumstances or agency and therefore can act as a major hindrance in conducting qualitative research. For example, there were several times where I had to turn down potential participants early in the recruitment process because of various meeting “restrictions” defined by ethics omitting public spaces for interviews (even if the participant requested and preferred such a place). That left me with very few alternatives and space to be accommodating to the participants. I was able to avoid this pitfall by interviewing in the homes of the participants when it was most convenient to their schedules (see comments to follow on rapport) and through conducting one interview via the phone when it was too far and difficult for me to travel to her home.

With that being said, with persistence and ethics approval in hand everything began to fall into place, including a CERIS Graduate Student Research Award that I received for this study. The award came with a small research grant that allowed me to provide all the participants in the study with a \$25.00 honorarium and TTC tokens if necessary. Many of the women in this study are mothers and grandmothers, working multiple jobs; their time is valuable, and they deserve to be compensated for their participation, travel and childcare needs through an

honorarium. The grant was also used to purchase a recording device for the interviews; as well as photocopying and printing needs.

The group of participants in this study does not form a representative sample of hotel housekeepers in the GTA. Instead, this paper takes a narrative analysis approach which uses the narratives of the participants as empirical evidence in which qualitative data can be analyzed. I chose a qualitative framework for this study because it allows traditionally silenced voices to be heard and it fosters better comprehension of those naturalized discourses that exclude and marginalize certain groups (Hay, 2005, p. 17). I was originally looking for 5 to 8 participants and decided that five would be enough for the purposes of collecting and analyzing narratives; and to be mindful of the time factors involved. The interviews were semi-structured and were slated to take approximately 60 minutes, some went slightly over and others were under. Participants were all asked the same core questions; the prompt questions varied depending on various responses (See Appendix A for the Interview Guide).

The criteria set for the selection of women participating in this study were as follows: they had to self-identify as an immigrant woman of colour; currently be working as a unionized hotel housekeeper in the GTA⁷; and lastly, they needed to be able to speak about their health and well being prior to working in the hotel industry and after. I was given informed consent from all participants to record their interviews to allow for further analysis and accurate documentation of their individual narratives. Each participant was given the choice to choose their own “alias” for anonymous allocation in this paper to protect their identities. It was also a way for the women to see their contribution to this body of work and to be able to identify themselves while reading

⁷ There were two variations that arose during the interview process. The first was that one participant was currently on a leave of absence from work to pursue activist work with the union and the second was a participant who was no longer a housekeeper but had gained some upward mobility into hotel maintenance. This did not affect the rigor of the sample because both women’s narratives addressed the core questions and were more than relevant to the discussion at hand.

this paper. All of the participants were keen about reading this paper upon completion and I happily agreed to send all five women a copy when I was finished. It should be noted that one participant did not want an anonymous allocation in this paper because it was her truth, her story and experiences and felt strongly that I used her real name, which I did. This is a perfect example of how the blanket application of rules and rigid ethical guidelines in regards to confidentiality does not consider individual circumstances or agency the participants have to make informed decisions for themselves.

To recruit the participants I used two methods “snowball” or “chain sampling” as it is also known, which identifies cases of interest who know other people with relevant cases. I also used “opportunistic sampling” where the researcher is flexible and open to following new leads during field work and takes advantage of the unexpected (Hay, 2005). The unexpected arrived in my inbox on July 31st, 2008 informing me of a rally to take place that day in support of immigrant workers in the GTA, at Toronto City Hall. I thought this would be a great opportunity for me not only to show my support but to conduct observational research given the focus of my paper. The Immigrant Workers Rising⁸ rally began at Toronto City Hall and then proceeded down Bay Street to the front of the Royal York Hotel to support the workers who at the time were involved in contract talks with the historic hotel (full details about my observations can be found in the chapter on Resistance and Negotiation). While at the rally, I had the opportunity to speak with some hotel housekeepers and share with some of the women about my research; they were intrigued and agreed to meet with me to share their stories.

⁸ “Immigrant Workers Rising” is also known as the “Hotel Workers Rising” campaign initiated through UNITE HERE. Thousands of hotel workers in unionized properties across North America are rising up through various means such as political action and rally’s to bring attention to their work situations, improve their jobs and secure better lives for themselves and their families. More details in the chapter on Resistance and Negotiation (hotelworkersrising.org, 2008).

In reflecting back, there was a strong rapport and solidarity with the women I was speaking with at the rally, which also carried into the interviews. They were not only interested in my choice of a Masters program (Immigration and Settlement Studies) but to know that my research was genuinely interested in hearing and writing about their experiences meant a lot to them, and they had a lot they wanted to share on the topic. One participant mentioned that she granted me an interview to support me as a fellow woman of colour. It is undeniable that my own social location had significant advantages in this situation in terms of being “an insider”. I was invited into many of the participant’s homes to conduct the interviews and given their home telephone numbers which in turn shows trust in the researcher and their work. Given that all the women in this study were of Caribbean decent, my ability to engage in conversation and understand the Patois dialect that the majority of the women were speaking with; allowed me to understand phrases and small nuances in the conversation that would be so easily missed by an “outsider”. An “insider” is someone who is similar to their participants in many respects, while an “outsider” differs significantly (Hay, 2005). One position suggests that as an “insider” the information you collect and your interpretations of it are more valid than those of an “outsider” (p. 26). For instance participants are more likely to speak with you freely and you are more likely to understand what they are saying because you share a similar frame of reference. If you are not of the same social group establishing rapport may be more difficult, however, some may argue that “objectivity” involves distance between the research “subjects” and the researcher.

Mullings (1999) in her work entitled “Insider or Outsider, Both or Neither: Some Dilemmas of Interviewing in a Cross-Cultural Setting” describes the complicated dynamics in which identities and their attendant power relations are created and transformed during the research process. She describes that in her own study that took place in Jamaica that even though

she was far removed from the “social world” of factory workers and employers, she did share the positionality of African decent and familial roots in Jamaica. This allowed her partially and temporarily to inhabit space, within the firms and factories and build a rapport with those she was interviewing. While positionality is not focused on or promoted by the researcher, Mullings argues that recognizing and naming these uncertainties and dynamics is an important step towards establishing rigor in the research process. Similar to Mullings, my own social location (race, gender, age, class) and commitment to inquiry from a feminist political economy perspective has shaped my motivation and choices in this study which is a position that I laid out very early on in this paper.

Narratives: Sylvia, Georgia, Celess, May and Esmey

The following five narratives are based on my individual interviews with women working in the hotel industry as housekeepers. The narratives are presented as an account of their personal experiences in relation to the various open-ended questions put forth in the Interview Guide (See Appendix A) which was created to help fill the various gaps found in the literature review. The narratives will be analyzed in more detail in the findings section to follow. The women and their narratives will be introduced to the reader in no particular order or preference and have been summarized from their original conversations with me. It should be noted that “housekeeper” will be used interchangeably with “room attendant” because many of the women referred to themselves as such in the interviews; however, there is no difference between the titles. As well, things that may appear as “typos” or “incomplete sentences” in the narratives are simply just a reflection of the Patois dialect, and the way the women chose to express themselves in our conversations.

Narrative 1

Sylvia Gordon came to Canada in 1983 from Jamaica and is married with 6 children, 2 stepsons and many grandchildren whom she takes great pride in. She is 61 years of age and has worked as a Room Attendant in the GTA for a total of 18 years. She works at a full-service airport hotel, where she has been for the past 13 years and makes \$14.00 per hour; however, she recently took a leave of absence from her job to pursue activist work for the union.

When asked to reflect back and rate her health before she started working in the hotel industry, she rated her health as excellent; placing herself as a 9 on a scale of 1 to 10 (1 being poor and 10 being excellent). In the first five years of working as a housekeeper she was at a non-unionized property where she developed a pinch nerve in her shoulder that she had to “receive needles for”. She has now been working in a unionized property for the past 13 years and describes more work-related pain in her hands and fingers that causes numbing and tingling sensations. She describes that gripping and pushing the heavy cart and forceful movements like forcing large pillows into the small pillow cases repeatedly has led to swollen fingers. “There was one day that my hand felt dead” but she worked through the pain. It became too much so she reported it to management and went to the doctor. The x-rays showed a torn ligament in her hand. “There is so much pulling and tucking that you have to do with the bedding”, which according to her doctors was the source of the injury and added to the hand and finger pain. Sylvia was on medication for 8 months and had to do physiotherapy. On top of that, she describes pain in her shoulders, back and knees. “My knees began to hurt” from bending and pushing. She mentioned that she would have to use her own time for physiotherapy and lost wages because the services were only accessible during the day. “We have negotiated health benefits in our contract but because our hours are so long and our work is so physical we don’t have the time or energy to use them [benefits], your body is dead, you are beat”.

When asked about health hazards in the workplace, Sylvia mentioned a time at her hotel where there was an outbreak of rashes among the housekeepers, including herself, due to the harsh chemicals used on the linens. She is also very weary of the chemicals she has to work with. She describes how the skin on her fingers would peel; “your hands are so rough it would tear fabric, your stockings. We hide our hands, you are so ashamed”. When asked to rate her health now on that same scale that she rated herself on prior to working in the industry; her health dropped from “excellent” to “poor”.

Even with the struggles she faces, Sylvia works to take control of her health and stress relieves through gardening and reading. “I’m on the bus I read. I laugh with my kids and grandchildren. I like to watch documentaries and I watch Oprah. I try my best to eat healthy”. Sylvia at 61 years of age is working to change these situations for the next generation of housekeepers in her activist work with the union. She remains engaged and active in her community.

Narrative 2

Georgia Coley is 58 years of age and has worked as a Room Attendant for 32 years. She came to Canada in 1972 from Jamaica. She is married and has three children and four grandchildren. Georgia makes \$11.80 per hour and has been working in a full-service Mississauga hotel for the last 12 years and she enjoys her work, even with its many problems, she is very proud of what she does. When asked how she would rate her health prior to working in the industry on a scale of 1 to 10, without hesitation she answered 10, excellent. “I remember when I started they would tell me to slow down, you work so fast”. When asked again about how she would rate her health now, she rated herself as a 5 out of 10, and mentioned that she was blessed because there were many women in the industry that had it worse than her.

When Georgia described a typical day at work and various tasks that would trigger pain she described that as a housekeeper you have to go on your knees in every room to look under bed and doing that repeatedly from room to room was strenuous. She also mentioned the shower stalls being the most difficult on the body, especially with the new “spa shower stalls”. “You have to stretch up and it’s dangerous because you can slip, your shoulders and back hurt”. During the interview she got up and reenacted how she had to enter the spa shower because cleaning it is so hazardous, “it’s an accident waiting to happen, I have to spread a towel so I don’t slip. You have to come up with strategies and ways of protecting yourself. When I was younger I would get down on my knees but now I refuse, I need these knees to carry out the rest of my life. You know why I have lasted so long, because I have seen people try to be superwoman and it doesn’t work. When your body tells you to stop, you need to know when to stop. Your body is telling you don’t, don’t, don’t...I must retire healthy so I can enjoy my life”. Georgia’s wisdom is inspiring and she acknowledges that it is not as easy for some of her fellow co-workers especially the newer women in the industry, who are often newcomers to Canada, to be as bold. She recalls often speaking up on their behalf.

To take control of her health and well being she believes that her faith has sustained her in many difficult times and believes that God cares about workers. She listens to music as a way to stress relieve; gospel, soul and Motown in particular, and she loves to dance. Georgia even with her busy work schedule and tiredness at the end of the work day is devoting her spare time to working in the Rexdale community; she also supports many union activities and speaks passionately at hotel worker rallies.

Narrative 3

Celess West is 52 years of age and has been working as a Room Attendant for the past 25 years. She is married and has one child and three grandchildren that she enjoys spending time with. Celess came to Canada on a two year work permit as a domestic worker in 1979 from Jamaica. She describes her first years in Canada as lonely times and often wanted to go back but she stuck it out for a better life. She disliked being a nanny and left domestic work and went into hotel housekeeping where she has been at the same downtown Toronto full-service hotel for the past 20 years. She makes \$16.75 an hour and estimates she might have started around \$5.25 per hour. The hotel property since she has worked there (20 years) has been unionized.

Celess without hesitation rated her health prior to working in the hotel industry as excellent (10), “I was strong, young and healthy, no problem”. When asked how she would rate herself now on that same scale, she said she rated herself as a 3, very poor. In the interview she pointed to her fingers and arms, “I have been on modified duties for a while”. She revealed that she has carpal tunnel on the left side and has seen specialists and has even contemplated surgery. But due to the uncertainty of outcomes associated with carpal tunnel surgery she has opted instead to wear a wrist splint at night. She mentions that she is very dependant on her husband now to help her carry out tasks in the home that she used to have no problem doing; from washing dishes to carrying the laundry basket and vacuuming.

When describing a typical day on the job she describes the constant stretching and bending while cleaning the hotel rooms as a source of pain in her back and shoulders. Fixing the bedding and tucking the sheets also causes pain in her fingers. She mentioned that sometimes you are working so fast that you don’t even know where it was you hurt yourself. When addressing hazards in the workplace she mentioned a time when she fell while trying to hang a shower curtain and she hit her knee on the way down. She now refuses to do that task and calls the maintenance crew in to hang shower curtains.

With years in the industry she has found a boldness and ease with confronting supervisors, knowing that she has the union to back her up. At her property there are many new housekeepers that have come in from the Philippines. Celess finds herself speaking up for the new women, who in her observations, supervisors try to take advantage of them.

Her faith, going to church, helping out in the church community and spending time with her grandchildren helps her to stress relieve. Celess throughout the interview finds ways to laugh and stay light hearted and in closing mentions that she always attends the rally’s to support her fellow housekeepers in their fight to improve the standard for all working in this industry.

Narrative 4

May Brown came to Canada in 1970 from Jamaica. She is now divorced with three grown children and is excited about her grandchild on the way. Although she would not share her exact age, she did mention she was between 60 and 70 years of age. May has worked in the industry at the same downtown Toronto full-service hotel for the past 35 years. When I asked about her official job title she jokingly said “everything in working order”. May has a very interesting story in that she had worked as a hotel housekeeper for approximately 9 of those 35 years before she fought her way into a maintenance position which was and continues to be dominated by men in the industry. She remembers making about 98 cents per hour or \$50 dollars a week when she started working as a housekeeper. In maintenance she now makes \$18.98, and her fellow housekeepers make \$16.60. She has been unionized at this property for the past 35 years that she has worked there.

When asked why she hasn't retired yet, she said that she was thinking about it, but she likes to keep busy “if I'm not helping people, I feel (pause)...I have been taking care of other people all my life. I do have a pension but it's not great, they started late”. When she rated her health before working in the industry, she did not hesitate to say a 10 (excellent), “I was young, rigorous, healthy, now...(she laughs)”.

A typical day in maintenance is very similar to a typical day in housekeeping. For example, she also has to push around a heavy cart full of tools, equipment and a vacuum. There is a lot of bending, stretching and reaching in awkward positions to fix things in the room, for instance drains under the sink and replacement filters in vents near the ceiling. These are all sources of pain in the back. May shared about the pain she suffers in her knees from the constant bending and kneeling. “The padding in my knees are worn out, I have to wear knee pads to do everything. I thought it was arthritis at first but the doctors told me my knee pads were worn out. That developed in maintenance but in housekeeping I got tendonitis in my right shoulder that still affects me today”.

May reminisced about how she managed to leave housekeeping; “I applied in maintenance (engineering) a long time ago, I was told there were no women allowed. It took me two and a half years of constantly applying and complaining to the union”. When she finally got the transfer from housekeeping to maintenance she was under probation and a watchful eye, but she did not let that intimidate her. “When I walked in I said “boys I'm here to stay”. “I knew most of that stuff because I was a tom-boy. I grew up watching my father doing his work. After my probation they were like “hell she is good” and before I knew it 25 years have passed”. She would like to see other woman get involved, because she opened the way. “I hope the young women would try it because it is a different experience from housekeeping, everyday there is something different”.

Although May claimed that she didn't have time to be involved with community work. She reminisced about her house always being a safe place for the children in the community. She would come home after a full shift at work to a full house of kids. As a single mother, not only did she raise her own children but also the children in her community. Many of the kids, who are now grown as adults, will stop when they see her in the community and say “Hello Miss. Brown, Do you remember me? I use to come to your home every Monday night for your oxtail”. She was not aware of the positive impact that she had on the kids in her community and that she offered them an alternative to the streets and a life of crime and drugs.

Narrative 5

Esmey Perkins came to Canada from Jamaica in 1974 and is 41 years of age. She has been working as a Room Attendant for the past 7 years at the same full-service unionized hotel near the airport. She is a single mother with one child. When she first started, she was connected to the hotel industry through a temp agency where she was paid \$9.00 per hour, and now makes \$14.84 per hour.

Esmey rated her health before working in the hotel industry as a 10, excellent, and now rates herself on the same scale as 5 out of 10. When she describes a typical day at work she often feels pain in her back when pushing the heavy cart and bending to clean. Her wrists and lower back would also hurt from making the beds. Some of the mattresses are very heavy and some rooms have two double beds that require her to spread and tuck three sheets, a duvet and a spread per bed. She has to clean 15 rooms a day regardless of their condition but she is a fast worker and can usually leave on time.

One of the hazards she describes on the job is when she has to work on the smoking floor. There is one floor in her hotel that is still dedicated to smoking rooms and “some don’t even have windows”. She has voiced her concerns to management and was told to wear a mask but Esmey feels that the masks are uncomfortable and that you cannot breathe properly wearing them. She describes the rooms as “very musty, the smoke is all over, its just so closed up, nothing comes out”. She revealed that guests continue to smoke in hotel rooms that are designated non-smoking; the front desk even gives ashtrays upon request when guests are in non-smoking rooms. Housekeepers are supposed to report it and “Guests are supposed to be fined, but it is rarely ever enforced”. When speaking about hazards she also mentioned a “pink chemical all-purpose cleaner” that the housekeepers are suppose to use in the rooms but it has a really strong scent. Esmey does not use it anymore and uses the alternatives that are available to her.

When asked about if she saw any reduction in workload with being unionized she said no. When asked if there were any positive benefits to unionization she mentioned that “even if the contract say something like, they are suppose to work by the hour and not by the room, the management does not adhere to the contract and they try to bully the workers and some are just too scared to speak up”. The union’s benefits package on other hand is great and Esmey makes use of things like chiropractic care for her back and finds that it helps. Every morning Esmey tries to stretch before she starts work. She takes vitamins and she works out at the gym to try and keep fit and healthy. If she wasn’t so tired after work, she mentioned that she would get another job because this one does not pay enough.

Significant Findings from the Narratives

Health

The narratives speak volumes about the women's experiences in the hotel industry and their corresponding depletion in health as hotel housekeepers and as racialized immigrants in Canada. All of the women were asked in the interview to rate their health on scale from 1 to 10 prior to working in the hotel industry (1 being poor and 10 being excellent). They all responded that their health was "excellent" prior to working in the industry (see Table 3). When asked to rate how they perceived their health now, on that same scale, they rated their health as "poor or fair". These significant declines in perceived health is consistent with the literature presented, and furthermore, with the Healthy Immigrant Effect.

In analyzing the number of years that the women have worked in the hotel industry, cross referenced with when they immigrated to Canada, the findings showed a correlation between Years Since Migration (YSM) and a resulting depletion in perceived health and well being. As

Table 3
Participant Demographics

	Age Or Age Range	Health Before*	Health After**	Immigrated to Canada From Jamaica	Years Since Migration	Years working in the Hotel Industry	Room Attendant Current Wage
Sylvia	61	9	5	1983	25	18	\$14.00
Georgia	58	10	5	1972	36	32	\$11.80
Celess	52	10	3	1979	29	25	\$16.75
May	60 - 70	10	5	1970	38	35	\$16.60 \$18.98***
Esmey	41	10	5	1974	34	7	\$14.84

* Perceived health before working in the hotel industry (10 excellent – 1 Poor)

** Perceived health after working in the hotel industry (10 excellent – 1 Poor)

*** Maintenance Worker Wage

Source: Sirena Liladrie (2008)

discussed earlier, racialized immigrants surveyed in the Canadian National Population Health Survey had rated their health good, very good or excellent in 1994/95, but later described themselves as being in fair or poor health (Ng et al, 2007). These findings were also consistent with the literature on the Healthy Immigrant Effect which is an observed time path showing that immigrants arrive in the new country with optimal health but it continually depletes with Years Since Migration (YSM). This phenomenon is particularly evident among “first world” immigrant receiving nations like Canada. Similarly, Lee and Krause (2002) found that the overall health status of housekeepers in their American based study appeared to be worse than the general US population. Self-rated health by the housekeepers averaged at 56 percent which is significantly lower than the general US population average of 72 percent (p. 227).

One of the prevailing arguments made to explain the downward depletion in health is blamed on the elderly workforce. However, Lee & Krause also found that equally high rates of musculoskeletal symptoms occurred in both young and older housekeepers. The findings in their San Francisco study suggest a correlation between poor working conditions and reduced health outcomes for hotel housekeepers regardless of age. In my conversations with Esmy, who was the youngest woman to participate in the study at 41, she perceived her health as a 10 before working in the industry and now, only after 7 years as a housekeeper, her health had depleted towards a 5; which was also consistent with the older women’s declines in health since working in the industry.

Retirement and Pensions

One of the major findings in this study had to do with the questions surrounding issues of retirement and pensions. Given that the majority of the women in my study were above 50 and

60 years of age, this was an issue that many were dissatisfied with and fearful of what the future may hold. For example, Sylvia commented that the company she works for is “throwing the older workers out like garbage” when they have to go on modified duties because of work-related injuries. “When you work in the industry as a room attendant and you are 59 and 60 years old, who is going to hire you? I am 61, who is going to hire me when this company throws me out?” Similarly, Esmy spoke about some of her fellow co-workers that have been with the hotel for up to 20 years, and are now on modified duties due to work-related pain and injury.

“Management has cut their hours to part-time. One woman was even let go. They were literally told they are useless to the company”. Georgia passionately remarked, after telling me that she herself did not have a pension after 32 years of working as a housekeeper, “people need to retire with dignity...all they [corporation] care about is making money. They are slave owners, they don’t care about the slaves, they only care about the cotton being picked”. Her comments and feelings are more than valid through a critical race and political economy perspective. The systems of the past which justified race as a means to procure free and cheap labour are alive and well in contemporary capitalism. The capitalist goal is to create profits by keeping the costs low. The billion dollar corporations behind some of the most familiar hotel chains are doing just that, by taking money out of the workers’ pockets by denying them benefits, such as good pensions and retirement packages (that they themselves are entitled to and receive working in the same corporation as the housekeepers) reveals inherent structures of inequality.

Some of the women did mention that they have a pension but it was always followed up with comments like “they are not worth much” and “our pensions are horrible”. In my conversation with May, who is in the age range of 60 and 70, I asked her if she has any plans for an upcoming retirement, she said that she was thinking about it, but she likes to keep busy. “If

I'm not helping people, I feel (pause)...I have been taking care of other people all my life. I do have a pension but it's not great, they started late". May's narrative shows the multiple roles and responsibilities immigrant women take on in both their work, home and community lives. It also shows that her options are limited in terms of making decisions around retirement. Similarly, in my conversation with Sylvia she revealed that many housekeepers are fearful that when they retire they will still have to go out and find another job because "our pensions are horrible". Older housekeepers contemplate having to find part time jobs to make up what they will get from the government. She goes further to say that even though the unions have had some success in negotiating pensions; it is the younger housekeepers that will benefit from those gains in the future. According to Sylvia, the union (Local 75) has recently placed pensions as a priority in collective bargaining for room attendants and hotel workers so that "after they leave with all the pain and all the injuries, they don't have to go out and baby sit someone else's kids to make-up a living, or go and clean someone's house".

According to Elgersma (2007) immigrants face a double disadvantage in the Canadian pension system. First, acquiring public pensions is problematic for immigrants given the residency requirements and second, the accumulation of pension assets through the Canadian Pension Plan (CPP)⁹ or private pensions is also challenging due to the difficulties in integrating fully into the Canadian labour market. 45 percent of near retirees who had immigrated to Canada since 1980 believe their financial preparations for retirement were inadequate (Elgersma, 2007, p. 2). Trends in the hotel sector are similar to the broader Canadian labour market which forecasts that by 2011 almost half of the labour force will be over 55 and 18 percent will be over 60. Furthermore, the removal of the mandatory retirement age of 65 will result in more senior

⁹ Canadian Pension Plan is a social insurance program based on contributions and earnings. Anyone who has made at least one valid contribution to CPP is eligible to receive a monthly retirement pension starting at 60 years of age (Elgersma, 2007).

workers remaining in the labour force longer, as is mirrored in May's narrative (Verma et al., 2006, p. 17). The women's narratives highlight the multiple roles that many immigrant women of colour take on both at home and at work, this exacerbated by the lack of options these women have in their senior years is an area in need of further research and policy intervention. Pensions and retirement is a significant gap in the literature in regards to the hotel industry and a very important arena for research and policy work given the aging population in Canada and the growing body of literature on poverty among immigrant seniors in the GTA.

Racism and the Racialized Division of Labour

Racism and systemic barriers to upward mobility in the hotel industry is also a significant finding in this study. When I asked Sylvia if she noticed if there was a racialized division of labour in the hotel where she worked, she without hesitation went on to describe the entire racialized hierarchy of the hotel. Starting with the management and office workers (Human Resources and Sales), were all white, except for the odd token "minority". At the front desk they are white men and women; but black men and women, and other racialized workers, worked in the back of the hotel. Mostly in the kitchen as prep cooks (but not chefs), servers, dishwashers, porters, and the women as room attendants. At Celess' hotel it was very similar; she said that "all the front desk staff were all white people. Sometimes they pass you in the hallway and they don't even look at you. The supervisors say we have to say hi to guests and smile. How they can tell us that when they don't even do that with us?" She went on to describe how she is not allowed to enter the hotel through the front doors "We have our employee's entrance we are not allowed to walk through the front door. They always say "Employee Entrance Please". However, the workers at the front desk, who were described as being white, can enter and exit through the

front door as they please. Celess' comments reveal condescending attitudes and racialized divisions at her hotel. Upon hearing her story, I couldn't help but make the connection to the once racist sign of the past that read "no coloured's allowed". Now it is a sign that reads "employee entrance" at the back of the hotel.

Celess' and Sylvia's accounts of a racialized division of labour in their hotels is not a figment of their imaginations. In fact, it is consistent with Statistics Canada 1996 census tabulation of selected GTA labour force characteristics based on occupations in the hotels and motel industry (Tufts, 2006, p. 203). It shows that the majority of white employees work in the "front-of-the-house" and are more likely to have management jobs, while racialized workers and immigrants are relegated to the "back-of-the-house" where they dominate in cleaning, kitchen, laundry and housekeeping. For example, the tabulation showed that 63 percent of executive housekeepers were visible minorities and that 82 percent of light duty cleaners were also visible minorities. In comparison, Accommodation Service Managers were 25 percent visible minority and 56 percent Canadian born (non-racialized) (Tufts, 2006, p. 203). Celess also mentioned that if there is an available position in the hotel, and "they" apply for it, they are told they are not qualified. Management won't even look at their application. Sylvia commented that "you will be more qualified than some of the people at the front but because of your race or your ethnic background...the companies will say it's not so, you're not qualified, that's not true because we know more than some of those new people coming in. Sometimes they will say you have an accent and they want someone with perfect English at the front". Not only is skin colour a mitigating barrier for upward mobility, but accents and perceived notions of proper English are also barriers. These narratives are significant in bringing voice to the racialized and gendered experiences and systemic barriers these women face every day in the industry.

Personal Lives and Community Involvement

Another gap that was broached in the literature review surrounds the topic of how work-related pain affects the lives of hotel housekeepers both in their family and community spheres. I decided to tackle this question because work-related pain and stress is not isolated to the place of employment but carries over into many aspects of the workers life. I asked the women firstly about their home and family lives in relation to their work, Sylvia had this to say:

At the end of the day you get off the bus, it takes an hour and half to get home, you are dead in the chair and you can't have any social life, you don't have time to spend with your kids. You are so tired and stressed that it causes arguments in the home for no reason.

Georgia elaborates on the tension this can cause within marriages and partnerships given that she has seen first hand marriages brake-up because of the long, unpredictable hours housekeepers have to work, not to mention weekends and holidays. “You don’t have time for family life. Can you imagine dealing with all that stress and pain at work and then having to come home and be intimate with your husband?” The pain that housekeepers bring home with them has an impact on intimacy issues and the extent that these women can engage in fulfilling sexual relations with their partners. Celess described that with her carpal tunnel she is very dependant on her husband to help her carry out tasks in the home that she use to have no problem doing; from washing dishes, to carrying the laundry basket and vacuuming. Esmey said that “sometimes I come home I can’t cook, I’m too tired. Sometimes it’s like the bottom half of your back is ripping sometimes from the top, that’s how hard it is”. Fatigue after coming home from work was a common response from all the women, and it not only affected what they did in the home but also how they wanted to engage and participate in their larger communities. For example, Celess said “I’m a church lady and sometimes we have bazaars at church, sometimes we have breakfasts at church. I like to help them cook and stuff like that. Sometimes I’m okay

but sometimes the pain is too much”. Georgia says there are many times she wants to volunteer in the community but when she gets home she’s just too tired. Furthermore, the majority of these ladies take public transportation which often takes hours out of their day. Some of them work at hotel properties in downtown Toronto; given their wages, many cannot afford to live in the downtown core and instead reside in the outer core of the city where housing is more affordable but the commute is tedious.

Some of the women discussed the relationships that they had with their children and grandchildren. May reminisced about when her kids were younger “My kids played basketball and were in plays but I never had the time to go and see them. I think they were mad at me”. Precarious work, with its irregular hours and low wages leave many parents and single mothers like May struggling to balance family life with the economic imperatives. Sylvia spoke about the visible inscribing of her pain on her body and how that led to embarrassment and shame with members of her family and even in the community. “Sometimes your kids will look at you and ask you “why are your hands like that?” My grandkids will ask “Grandma what’s wrong with your hands?” I try to explain it’s because of the work I am doing...it’s so embarrassing”. Sylvia also talked about the skin on her fingers peeling because of the harsh chemicals she has to use and due to the harshness of the linens washed in commercial grade detergents. She also mentioned that her and the other housekeepers will compare their hands on the bus ride home. She describes her fellow coworker’s hands as discolored and rough, many of them when they were on the bus will hide their hands because they are so embarrassed. It is a sad story when the precarious nature of your work becomes a visible marker inscribed on the body, furthermore that it is a source of not only pain, but also embarrassment and shame.

Unionization and Health

Lastly, it is important to reflect on the women's narratives in regards to their reflections on unionization linked to their health and well being. I posed a question earlier in this paper questioning the literature claiming that unionized workers are better off, given the contradictory evidence of the experiences of unionized hotel housekeepers and their high rates of work-related pain and injury. To explore this further I asked all the participants how long they have been unionized at their current place of employment and to my surprise they all responded with, since they started working there. That would mean up to 35 years for some of the women, and as low as 7 years for the youngest room attendant in this study. The reason for my surprise is based on the perception that hotel sector is a newly organized industry, given the poor pay rates, lack of pensions and standards in the workplace; not to mention the very recent media and academic attention paid to this industry. The women's narratives helped to illuminate this discussion and debunk this perception.

A common response from the women in their conversations with me is that even though the union may negotiate and have gains in the collective agreements "it is not enough because the corporation puts more on us". Georgia describes that the rooms in 1970s were not as "loaded" as they are now. Cleaning 16 rooms then, is not the same as cleaning 16 rooms in 2008. In some hotel properties for example, the union has negotiated that the room quota be lifted and that room attendants work by the hour and not by the room. However Esmy when asked about if she saw any reduction in workload with being unionized she clearly said "no". When asked if there were any positive benefits to unionization she mentioned that "even if the contract say [sic] something like, they are supposed to work by the hour and not by the room, the management does not adhere to the contract and they try to bully the workers and some are just too scared to

speak up”. On the other hand, room attendants like Georgia, Celess, May and Sylvia all described using the negotiated terms in their union contracts to refuse work and negotiate with management about their workloads, and the workloads of their co-workers who may be more shy or scared to speak up.

All of the women were very positive about the unions benefit package as something that supports their health and well being in positive ways and gives them alternatives for therapy and treating their pain. This was also consistent with the employees at the unionized hotel branches in Zuberi’s (2007) study were also positive about the union benefits as a safety net, with concrete programs and benefit packages. However, many of the ladies commented that even though they have an extensive benefits package through the union, many simply can’t make use of things like massage and chiropractic care given their work hours and the loss of wages associated with taking time off work. This was also reflected in Egan and Gardner’s (2005) study which listed underemployment as one of the structural barriers to accessing mainstream (or alternative) health care.

Others mentioned several times that that “the union is fighting for us” and said that the union has offered them a platform to speak about their experiences. Sylvia stated that the conditions for room attendants would be much worse if it wasn’t for the unions. It is more than evident that unionizing and collective bargaining is complicated and multifaceted. While there have been small gains, and yes union wages are higher than non-unionized wages, they are still far from adequate for housekeepers to live a life free from pain and injury in the workplace. The evident struggle with unionizing racialized precarious workers is a result of larger structures of inequality in Canada’s labour market that has served to disadvantage immigrant workers regardless, if they are unionized or not.

These findings have highlighted declines in perceived health in correlation with the Healthy Immigrant Effect, issues surrounding pensions and retirement, the racialized division of labour and racism, and lastly on the participants reflections on unionization and its benefits or lack of in regards to their health and well being. The women's narratives and conversations with me confirmed many of the findings presented in the literature review from poor health outcomes to the intensification of work for hotel housekeepers. In addition, their narratives have highlighted gaps in the literature discussing how work related pain affects the lives of housekeepers in their family and community spheres; racism and the racialized division of labour; and unionization linked to the health and well being. This work has also contributed some original findings not addressed in the literature. The first being the significant link in the downward deterioration of the health of hotel housekeepers since immigrating to Canada to the phenomenon known as the Healthy Immigrant Effect. And secondly, the discussion surrounding the various fears and uncertainty about retirement and pensions for older housekeepers working in the hotel industry. There were many other linkages made in the women's narratives in regards to strategies for resistance and personal ways of taking control of health and well being through organizing and rallying, this will be discussed in more detail in the following section.

RESISTANCE AND NEGOTIATION: ORGANIZING AND RALLYING

...so I'm angry. But I am not without HOPE. This summer, we have been coming together as immigrant workers, as members of immigrant communities, as service sector and hospitality workers. We don't have to accept things the way they are. We don't need to accept poverty in our neighbourhoods. That every child in Toronto can grow up to be whatever they dream of being. That our jobs be good jobs where we are treated with respect and earn enough to support our families and communities.

Look around at the people standing next you. We are from all over the world. We are immigrants. We are Canadian. We are hotel workers. We are restaurant workers. We are beautiful! And together, WE ARE THE NEW MAJORITY IN TORONTO!

Zeleda Davis – Vice President of Local 75
Speaking to the crowd at Toronto City Hall on July 31st, 2008

With the rise in precarious work in the contemporary labour market there has been an increase in the rates of poverty. Those who are most effected are women, immigrants and immigrants of colour who face considerable obstacles in securing a living wage, and barriers to union organizing (Cranford, Gupta, Ladd & Vosko, 2006). Some of the barriers to unionizing hotel workers in the GTA according to Tufts (2006) include communicating to workers in their own language given the ethnic diversity in the workforce. As well, given that many of these workers are in very vulnerable positions they tend to be more cautious of organizing in fear of reprisal or backlash from the employer. Gender, ethnic and income segmentation creates challenges for solidarity and organizing and often the corporations will use these as a source to create divisions among the workers and “union bust”. Multinational hotel companies invest significant resources to suppress union organizing and have become quite sophisticated in their efforts which include surveillance of the workers and the hiring of union-busting consultants. Therefore, innovative strategies are imperative to enabling all workers to defend their rights and as such collective bargaining has taken on a “renewal” of sorts with a focus on community

unionism and coalition-building as seen in the recent strategies of UNITE HERE (Kumar and Schenk, 2006; Cranford, Das Gupta, Ladd & Vosko, 2006).

UNITE HERE is a progressive labour union, representing approximately 50,000 workers across Canada in the distribution centre, retail, manufacturing, hotel, restaurant, textile, laundry, gaming and food service industries (unitehere.ca, 2008). These industries employ large numbers of immigrant women of colour and UNITE HERE is committed to raising the standard of living for these workers who do some of the most “invisible” work in North America. UNITE HERE Local 75, represented approximately 7,500 hotel workers in the Greater Toronto Area in 2006 and this group, largely comprised of immigrant women of colour, significantly supported the efforts of the “Hotel Workers Rising” campaign launched in December 2005 (Tufts, 2006, p. 201). “Hotel Workers Rising” is a force that has swept across North America and is having a major impact in the GTA. The campaign is in conjunction with UNITE HERE, fellow unionists and activists in solidarity with the movement. The goal is to raise standards of work and living for those employed in some of the most strenuous, underpaid jobs in the service sector.

There are multiple innovative strategies and events linked to this campaign. I was able to both observe and participate in a recent workers rally that occurred on July 31st, 2008 in support of immigrant workers in the GTA, at Toronto City Hall. The Immigrant Workers Rising/Hotel Workers Rising rally began at Toronto City Hall and then proceeded down Bay Street to the front of the Royal York Hotel to support the workers involved in current contract talks with this historic hotel (See Appendix B For Pictures From The Rally). The rally followed after a collective of union members including Vice President of Local 75, Zeleda Davis, presented City Councillor, Gord Perks, with over 4000 pledge cards signed by hotel and immigrant workers (Freeman, 2008). Zeleda Davis is an immigrant woman of colour who has worked as a room

attendant for almost two decades. Her activist work and involvement with Local 75 is significant as a woman of colour on the forefront of this movement and there are others just like her who are dealing with the realities of their work in the hotel industry, yet contest and negotiate actively. When Zeleda addressed the crowd in front of Toronto City Hall (an excerpt from her speech can be found introducing this chapter) she ended her speech by saying:

Look around at the people standing next you. We are from all over the world. We are immigrants. We are Canadian. We are hotel workers. We are restaurant workers. We are beautiful! And together, WE ARE THE NEW MAJORITY IN TORONTO!

This new shift in language and positionality from “minority” to “majority” is a strong message being sent to employers and politicians; harkening that these issues simply cannot be ignored or dismissed because there is power in numbers, not just symbolically but statistically both internationally and on a local scale in Toronto. These messages are being conveyed and taken up in Zeleda’s statement and on the signs carried by the workers in the rally depicting a picture of the world, reading “We Are The New Majority” and on the other side “52%” (See Appendix B). According to the recent Statistics Canada census, immigrants now represent 52 percent of the growing population in Toronto (unitehere.ca, 2008). Furthermore, according to the Institute for Work & Health (2008) immigrants will account for all labour force growth in Canada over the next five to six years.

When the speeches ended at City Hall, the rally proceeded down Bay Street just as many of the corporate workers were heading home for the day. It was interesting to observe their bewilderment, as the rallying workers beat on their plastic buckets, blew on whistles and chanted “The-Workers-United-Will-Never-Be-Defeated”. This disrupted the space in the financial district and drew attention to the workers and their cause. The rally rounded the corner at Front Street where hundreds swelled outside the Royal York Hotel. A make shift podium was erected and more speakers came to the microphone to voice their stories. One of the room attendants

passionately spoke about her health and well being and equated the work of hotel housekeeping with “breaking the body”. One of the last acts of resistance was when the organizers asked everyone to hold hands and stretch out around the perimeter of the Royal York Hotel. This showed worker and activist solidarity and again this disrupts space, given that these workers are usually invisible in these spaces and are now in the forefront of an industry revolution.

One of the major strategies of the rally was to place pressure on the Royal York negotiations and it worked. Approximately 30 hours after the rally a deal was reached at 2am in the morning. A Toronto Star article reported that the union achieved all its major goals including workload decreases, increases in benefits, retirement income, wages and other income gains (Freeman, 2008). As well, the union’s contract with the Royal York and other GTA hotels are set to expire in 2010. This will put 6000 hotel employees in a position to negotiate contracts at the same time, which will help significantly to set a standard across unionized hotels in the GTA.

While there has been advancement for immigrant women of colour working as hotel housekeepers across North America, and locally in the GTA, the struggle still continues. This is a multifaceted struggle as labour contexts continue to shift with the whims of neoliberal globalism and continues to remain dependant on racialized and gendered workers. As described, many women in this industry are voicing and organizing, they are not simply passive victims in these processes, but are contesting and negotiating in their places of underemployment through collective action, union formation and networking. This process can be furthered with the continued effort of progressive unions like UNITE HERE to incorporate immigrant women of colour into the ranks of the union structure. This is needed to move beyond racial symbolism and tokenism of union frameworks past and present.

TAKING THE “HIGH ROAD” IN THE HOTEL INDUSTRY

The Toronto Task Force on the Hotel Industry, has outlined extensively in their report entitled “An Industry at a Crossroads: A High Road Economic Vision for Toronto Hotels” various recommendations and policies based on what they call a “high road” approach (See Appendix C For The Full List Of Recommendations). The task force was initiated by UNITE HERE which called upon leading experts from academia, community organizations and training institutions to research and make recommendations towards the “high road” proposition. The “high road” approach can differ in structure, employ different strategies and have different funding sources, but they share a common goal to build an economy based on skills, innovation, opportunity, sustainability and equitably shared prosperity rather than “low-road” practices that lower living and working standards and weaken economies (Verma et al., 2006, p. 1). A high road economic partnership between employers, unions and workers is the “best practice” to benefit everyone involved. For example in terms of health and well being, the taskforce made some practical recommendations that hotel employers who adopt the high road approach should ensure. Starting with implementing humane workloads and reasonable work room quotas based on the realities of the hotel environment. They also recommended a comprehensive re-design of equipment with ergonomically designed tools with long handles, increased staffing and enforced break times. And lastly, that there be more and better health and safety training for supervisors and employees (Verma et al., 2006).

The task force also calls upon government stakeholders, who have direct financial and policy interests in this 22 billion dollar Toronto industry that employs over 30,000 workers and creates nearly 700 million dollars in tax revenue to become a part of the high road strategy:

We believe the City of Toronto has a unique leadership role and we urge Mayor David Miller and the Economic Development Department to take the lead in creating a

mechanism with which to build a multi-stakeholder partnership that includes industry, labour, government, industry associations, educators and trainers, and community based agencies to promote a high road economic vision for Toronto's hotel industry (Verma et al., 2006, p. 1).

I would go further to say that one of those stake holders should be Toronto Public Health. Given that the Healthy Immigrant Effect exists in Canada; the evidence suggests the need to direct policy and funding initiatives towards the maintenance and promotion of immigrant health directly linked to their spaces of underemployment. Toronto Public Health currently has a “Health Options at Work” team that should be partnering their resources with ethno-specific agencies in Toronto that are not as well funded as them, but are more connected to the current conditions of precarious workers and their needs. Furthermore, proposed policy and funding initiatives should focus on the not-for-profit sector to fill the gaps, due to their ability to be more effective in the delivery of ethno-specific services. Not-for-profits have closer ties to local communities, greater flexibility and the ability to attract voluntary contributions of time and money (Jackson & Sanger, 2003). Policy and funding initiatives directed towards the not-for-profit sector is essential to fill the gap in current mainstream services to improve the long term health and wellbeing of immigrants. This can be done successfully through ethno-specific health agencies and the continued provincial funding of Community Health Centres, however, it is just the beginning in the process of counteracting the Healthy Immigrant Effect in Canada and its links to precarious underemployment.

Hotel Workers Cooperative/Training Facility

A very positive step in the right direction is the housing co-operative for hotel workers that has been approved by the City of Toronto and is a joint effort by the Cooperative Housing Foundation of Toronto, Toronto Community Housing Corporation and UNITE HERE Local 75.

It will be located at 60 Richmond Street. It is slated to have approximately 70 housing units which will be made available to hotel workers with choices for living spaces from an oversized one bedroom; plus, two, three and four bedroom units will be available. On the ground floor there will be classroom space for ESL classes and computer skills. As well as a professional kitchen, to be used for job skills and for training food and beverage workers. In addition to this training centre there will be a “Green Roof” with vegetable and herb gardens for the kitchen and tenant use. It will also feature recreation facilities, distinctive architecture and an extra green space built into different levels (Verma et al., 2006). This will allow hotel workers including those residing in Regent Park to live in a spacious building with opportunities for learning and socializing. It will also allow many to be within walking distance of their employment. I contacted Councillor Pam McConnell’s office to ask about the current status of this project and they responded that the co-op is currently on schedule and should be ready for occupancy next May or June 2009.

Conclusion

The women’s narratives and conversations with me confirmed many of the findings presented in the literature review from poor health outcomes to the intensification of work for hotel housekeepers. In addition, their narratives have highlighted gaps in the literature discussing how work related pain affects the lives of housekeepers in their family and community spheres; racism and the racialized division of labour; and unionization linked to the health and well being. This work has also contributed some original findings not addressed in the literature. The first being the application of the Healthy Immigrant Effect to the downward deterioration of the health of hotel housekeepers in the GTA. And secondly, the discussion surrounding the various

fears and uncertainty about retirement and pensions for older housekeepers working in the hotel industry. However, there is much research, analysis and activism that remains to be done so that these issues can be taken up in labour and health policy as a way to address, protect and promote the health and well being of immigrant women of colour in precarious work situations in the GTA. However, this research will help to identify that change in social status, including living below the poverty line, inequality and underemployment impacts greatly on the health and well being of immigrant women of colour. It is not simply enough to have a “one-size-fits-all” model for population health in Canada; especially when determinants of health are compounded and intersectional, leaving immigrants more vulnerable than the rest of the population. The current population health model used by Health Canada needs to be revisited and revamped to acknowledge that sub-groups of the population are at higher risks. These sub-groups need to be identified through more research on precarious employment and health and then subsequently targeted for health promotion initiatives connected to their work places.

There are larger structural processes intensified by neoliberal globalism that lend to racialized segregated labour for immigrant women of colour working as housekeepers in the hotel industry. This paper critically analyzed the organization of the economy and global city through a feminist political economy approach; which looked at the racialized and gendered division of labour and how that reproduces and transforms racial and social hierarchies. Historical discourse, labour reproduction and social constructions of race continue to allow these hierarchies to exist today; however, these hierarchies are being contested and negotiated by immigrant women of colour working in the hotel industry in the GTA who are literally sick and tired of their current work situations.

Resistance can take various forms. For many immigrant women of colour working within the hotel industry, agreeing to be interviewed and partake in studies and surveys is a form of resistance that should not be overlooked. They offered their narratives as a way to redress their experiences as housekeepers and provide a connection to how their lived experiences has resulted in low wages, intensified work conditions and poor health outcomes. They are not simply passive victims in this process but are contesting and negotiating in active ways, working to raise the standards in the hotel industry and in their communities.

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Appendix A: Interview Guide

Do Not Disturb/Please Clean Room: The Invisible Work and Real Pain of Hotel Housekeepers in the GTA By: Sirena Liladrie

Demographic Profile:

Job Title: _____

How many years have you work at this hotel (other hotels): _____

Age (or Age Range): _____

In what year did you come to Canada: _____

Ethnicity: _____

Marital Status: _____

Children: _____

Highest Level of Education: _____

Income (per hour): _____

At your current place of employment how long have you been unionized? _____

What is your resident status in Canada? Citizen []; Permanent resident [];

Migrant worker [], Refugee [], Other [] specify:_____

1. How would you rate your health on scale from 1 to 10 (1 being poor and 10 being excellent) before starting to work in the hotel industry?

Prompt: Why have you chosen that number?

2. Please describe what a typical day as a housekeeper would look like at your particular hotel?

Prompt: How many rooms would you clean per shift?

Prompt: Can you describe certain tasks that would trigger pain?

Prompt: Is there anything you would describe as hazardous to you health on the job? Ex: Chemicals, situations?

3. How does this affect you family life? Community life and in what ways?

4. With unionization was there a noticeable difference in workload? What other differences if any occurred (benefits, transportation subsidies)?

Prompt: Do you have a pension?

5. How would you rate your health and well being on scale from 1 to 10 (1 being poor and 10 being excellent) in relation to your work currently?

Prompt: Why have you chosen that number?

7. What has unionization meant for your health and well being?

9. What are some of the ways that you take control of your health and well being in relation to your work?

Prompt: Is there anything you do in or outside of the home to take care of your health and wellbeing?

8. Are you involved in any community activism? Please describe.

9. Is there anything else you wanted to share before wrapping up this interview?

Appendix B: Pictures from the Rally on July 31st, 2008



UNITE HERE Local 75 signage.
Photo: Sirena Liladrie, 2008



Rallying workers leaving Toronto City Hall with Banner in hand, Ontario, Canada.
Photo: Sirena Liladrie, 2008



Workers protesting down Bay Street, Toronto, Ontario, Canada.
Photo: Sirena Liladrie, 2008



Taken in front of the Fairmont Royal York Hotel, Toronto, Ontario, Canada.
Photo: Sirena Liladrie, 2008

Appendix C: Recommendations from the Toronto Task Force Report on the Hotel Industry

1. Wages and benefits for all hotel workers must be brought to a living standard through negotiated agreements and a commitment by government to anti-poverty measures such as fair wage policies, increasing the minimum wage, and radically improving income security programs such as social assistance and employment insurance.
2. Too many hotel workers are segmented into job ghettos based on race and gender. All possible efforts should be made to eliminate racial and gender bias in hiring, promotion, and workplace practices through equity programs that are monitored by the employer and the union.
3. The right to union protection must be extended to hotel workers. The federal and provincial government must be urged to reform labour law and enforce our international commitment to recognize collective bargaining as a human right. We also call on all hotel employers to adopt the partnership framework on union growth agreed to by Hilton and Starwood.
4. A comprehensive training and equal opportunity initiative should be immediately implemented through negotiated training funds and supported on a financial and policy level by government. A city-wide Training Centre is an imminently achievable goal before the end of the decade.
5. A commitment must be made to ensure that hotel work is safe and satisfying by maintaining reasonable workloads, improving staffing levels and ergonomic design, and utilising the skills and experience of workers by varying tasks and rewarding good performance.
6. Work and family life can be enhanced through such measures as flexible working hours, personal days, workplace child care programs, extended parental leave and benefits, and joint labour management problem solving on issues of stress.
7. Housing, child care, and affordable transit are critical to truly increasing the standard of living and ensuring social inclusion for hotel workers. Employers should join with the union in urging all levels of government to restore funding for affordable housing and promoting mixed housing initiatives. All employers should meet the standard for subsidized transit passes agreed to by the Fairmont Royal York, Starwood, and Hilton. Affordable, accessible child care should be extended.

Source: Toronto Task Force on the Hotel Industry (Verma et al., 2006, p. 2)

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