

Electronic Thesis and Dissertation Repository

12-16-2022 11:30 AM

Examining the socio-economic and gendered structure of Canada's Live-In Caregiver Program: A qualitative study of Filipina women's health experiences

Andrea Bobadilla, *The University of Western Ontario*

Supervisor: Orchard, Treena, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree
in Health and Rehabilitation Sciences

© Andrea Bobadilla 2022

Follow this and additional works at: <https://ir.lib.uwo.ca/etd>



Part of the [Migration Studies Commons](#), and the [Other Public Health Commons](#)

Recommended Citation

Bobadilla, Andrea, "Examining the socio-economic and gendered structure of Canada's Live-In Caregiver Program: A qualitative study of Filipina women's health experiences" (2022). *Electronic Thesis and Dissertation Repository*. 9031.
<https://ir.lib.uwo.ca/etd/9031>

This Dissertation/Thesis is brought to you for free and open access by Scholarship@Western. It has been accepted for inclusion in Electronic Thesis and Dissertation Repository by an authorized administrator of Scholarship@Western. For more information, please contact wlsadmin@uwo.ca.

Abstract

The aim of this critical ethnographic study was to examine how Filipina women in the Canadian live-in caregiver program (LCP) negotiate their own physical and mental well-being while managing the complex health needs of their clients. Using global care chain and postcolonial theoretical frameworks, I also sought to identify how multi-scalar forces including caregiving and migrant policies in Canada and South East Asia exacerbate pre-existing gendered and labour inequities faced by these women. The distressing impact of this precarious form of employment on family dynamics and relationships among family members in the Philippines was also explored. Data collection took place in Canada and the Philippines, including interviews with 16 women who were in the LCP, 10 key informants in the Greater Toronto Area, and 15 key informants in Metro Manila. Findings highlight the complex transnational network of players and conditions involved in the international care economy, including migrant labour brokers, who significantly shape the experiences of migrant care workers upon arrival in host countries. Prolonged separation from family due to restrictive migrant care worker policies in Canada and around the world had significant effects on women's mental health, including persistent feelings of depression, sadness, burnout, and fatigue. Women had mixed feelings about their constrained relationships with their families, yet their perceived responsibilities to their families strongly dictated their decision-making with respect to their work, health, and managing their own daily living needs. These findings contribute critical data with which to develop gender and culturally-appropriate care, policies, and protections to advance the health and safety of these women, who perform essential care work in our country.

Keywords

Migrant care worker, global care chain theory, postcolonial theory, Canada, Philippines, migration, care work, gender, stepwise migration, migrant labour recruitment, migrant health, transnational family

Summary for Lay Audience

Canada has facilitated the immigration of migrant care workers to assist in the provision of care for children, the elderly, and those with disabilities since the 1950s. In 2014, significant changes were introduced to the live-in caregiver program, and of the many dramatic changes to the policy the reduced opportunities for permanent residency is particularly significant. The gendered and cultural make-up of the applicants in the program is striking, as women from the Philippines constitute 90% of admissions. My research explored the health experiences of Filipina women in the Canadian Live-In Caregiver Program, specifically how they maintain relationships with their families at home and manage their own health and well-being while working in Canada. In this ethnographic study, I took a transnational data collection approach with interviews conducted with migrant care workers and key informants in Canada as well as interviews with key informants in the Philippines to contextualize the social and economic conditions of both sending and receiving countries of migrant care labour. Using global care chain theory and postcolonial theory, my research contributes critical insights on the trajectory of these women's migration experiences, including their contrasting pathways to Canada, the influence of their familial responsibilities, the effects of prolonged separation on their mental health, and their exclusion from health and social services in Canada. Given the essential and deeply meaningful work migrant care workers perform, findings will contribute to refining health policy that serves their health needs as they continue to work and live in Canada.

Acknowledgments

Foremost, I would like to extend my deepest gratitude to the women who participated in this study. My research would not have been possible without the generosity of your time and your willingness to share your experiences with me. Thank you for trusting me with your stories and thank you for welcoming me into your community spaces and homes.

To my supervisor Dr. Treena Orchard, it is difficult to express the extent of my gratitude to you. Your friendship, guidance, and mentorship has been a great source of comfort during the most challenging times of this experience. I could not have done this without you and I owe much of my development as not only a researcher, but a critical thinker and writer to you. Your encouragement to explore ideas, along with your confidence in me and willingness to challenge me has fueled my growth and pushed my thinking. I would also like to thank you for your support of this research and the care you have always taken to help me bring these women's stories to life.

I am deeply grateful for the support, understanding, and encouragement of my advisory committee. Drs. Lilian Magalhaes, Debbie Rudman, and Suzanne Huot generously gave their time to provide feedback during the development of the study, challenge my thinking during advisory committee meetings, counsel me through fieldwork overseas, and review thesis drafts. Your kind words and brilliant questions have stuck with me through every stage of my experience and have truly shaped my academic development.

I graciously acknowledge the Centre for Global Social Policy at the University of Toronto for their financial support that enabled my fieldwork in the Philippines. I would also like to thank the faculty and staff at the Institute for Philippine Culture at Ateneo de Manila University. Your warm welcome to the community was truly helpful as I navigated my trip.

The support, patience, food, and laughs from my family and friends have also carried me through the most challenging times of my doctoral experience. To my family, Avnel, Sara, Ashley, Gerald, Mavec, Roberto, Nenita, Katrina, John, Cesar, Amy, Caylin, Colin, Calvin, and Jerome, thank you for always cheering me on. I also took great solace in the support of my friends: Kirsten, Jacqueline, Keriann, Karen, Joshua, Leah, Lauren, Kate, and Natasha. To Emily, thank you for your daily support, patience, keeping me fed, and always helping me

toward the finish line. I could not have done this without you. To my parents, Elizabeth and Avelino, for their unwavering belief in me, even when they found it difficult to understand what I was doing. My story is an extension of yours and I could not be more grateful and proud to be part of everything you have built. Thank you for everything you have done to help me get to this point.

Table of Contents

Abstract.....	ii
Acknowledgments.....	v
Table of Contents	vii
List of Tables	xii
List of Appendices	xiii
Chapter 1.....	1
1 Introduction of Filipina migrant care workers in Canada	1
1.1 Introduction.....	1
1.2 Research purpose	3
1.3 Relevance to existing research.....	5
1.4 Key changes to migrant care worker programs in Canada	7
1.5 Demographics of migrant care workers in Canada.....	10
1.6 Study significance.....	11
1.7 Thesis outline	12
Chapter 2.....	15
2 Synthesis of literature.....	15
2.1 Migrant care work.....	17
2.1.1 International perspectives on migrant care work	17
2.1.2 Canada’s Live-In Caregiver Program	18
2.2 Structural violence of the LCP.....	19
2.2.1 Precarious immigration status as a determinant of health in Canada	20
2.2.2 Employer-tied work permits as a deterrent from leaving poor working conditions	21
2.2.3 Delays in application processing times as symbolic bureaucratic violence	25

2.3	Exclusion from health and social services	29
2.3.1	Structural barriers to health care coverage.....	30
2.4	Long-term outcomes following the LCP	35
2.5	Summary	35
Chapter 3	.....	38
3	Methodology and methods.....	38
3.1	Introduction.....	38
3.2	Ontology and Epistemology	39
3.3	Theoretical framework.....	40
3.3.1	Global care chain theory	40
3.3.2	Postcolonial theory.....	41
3.4	Methodology	43
3.4.1	Critical ethnography.....	43
3.5	Data Collection	44
3.5.1	Data Source 1 – Migrant care worker interviews	49
3.5.2	Data Source 2 – Key informants in Canada.....	52
3.5.3	Data Source 3 – Key informants in the Philippines	53
3.5.4	Data Source 4 – Textual and material sources	58
3.6	Data analysis	60
3.6.1	Familiarizing myself with my data	61
3.6.2	Generating initial codes	62
3.6.3	Searching for themes.....	63
3.6.4	Reviewing themes	64
3.6.5	Defining and naming themes	64
3.6.6	Producing the report.....	65
3.7	Ethical considerations	65

3.7.1	Insider-outsider positionality	65
3.8	Conclusion	69
Chapter 4	.....	70
4	Pathways to Canada	70
4.1	Introduction.....	70
4.2	‘Imagined’ routes to Canada.....	74
4.2.1	Getting care work experience	76
4.2.2	Agencies.....	83
4.3	Philippines migration management.....	88
4.3.1	Training and skills acquisition	89
4.3.2	Processing times.....	93
4.3.3	Philippines pre-departure orientation session (PDOS) and post-arrival orientation seminar (PAOS).....	96
4.4	Discussion.....	101
Chapter 5	.....	104
5	The influence of LCP structural features on occupational health and safety hazards	104
5.1	Introduction.....	104
5.2	Characteristics of migrant workers	106
5.3	Receiving country conditions	109
5.3.1	Release upon arrival.....	109
5.4	Types of care work.....	116
5.4.1	Caring for older adults with complex conditions.....	117
5.4.2	Additional expectations of child care work	124
5.5	Discussion.....	127
Chapter 6	.....	130
6	Managing migrant health	130

6.1	Introduction.....	130
6.2	Health care coverage eligibility	130
6.2.1	Between employers and work permits	130
6.2.2	Open work permits and “implied status”	133
6.2.3	Provincial health insurance employment requirements	137
6.3	Navigating care	145
6.3.1	Delaying seeking care	145
6.3.2	Employer discretion	148
6.4	Major injuries suffered during LCP	150
6.5	Cancer	158
6.6	Mental health	163
6.7	Discussion.....	173
Chapter 7	.....	176
7	Discussion and conclusion	176
7.1	Introduction.....	176
7.2	Situating the key findings	177
7.2.1	Private recruiters as the de facto approach to accessing the Canadian labour market	177
7.2.2	Illegal recruitment produced conditions for workplace exploitation	180
7.2.3	Employer-tied work permits produced exploitative working and living conditions	182
7.2.4	‘Implied status’ extended precarity and uncertainty for migrant care workers.....	184
7.2.5	Constrained familial relationships	186
7.3	Continuing changes to migrant care work programs in Canada	189
7.3.1	Preventive protections against illegal recruitment.....	191
7.4	Reflections as an insider-outsider researcher.....	193

7.5 Conclusion	196
References	199
Appendices	214
Curriculum Vitae	230

List of Tables

Table 1: Breakdown of migrant care worker interviews	46
Table 2: Breakdown of interviews with key informants in Canada.....	47
Table 3: Breakdown of key informant interviews in the Philippines	48

List of Appendices

Appendix A: Letter of information and consent for caregivers	214
Appendix B : Letter of information and consent for key informants	219
Appendix C : Recruitment poster for caregivers	224
Appendix D: Recruitment poster for key informants	225
Appendix E: Life history interview guide for caregivers	226
Appendix F: Key informant interview guide	228
Appendix G: Research protocol ethics approval notice.....	229

Chapter 1

1 Introduction of Filipina migrant care workers in Canada

1.1 Introduction

The current demand for elder and home care in Canada exceeds the capacity of the health care system and it is anticipated that this crisis in Canada will intensify with the need for and costs of these services expected to double by 2031 (Deloitte, 2021). Home care makes up the largest part of these care needs, as nearly all Canadians prefer to age at home (Jones & Chhim, 2022). Finding labour to meet the growing gap in home care services continues to be a challenge, which has been exacerbated by the effects of the COVID-19 pandemic. For decades, Canada has relied on temporary foreign worker (TFW) programs to facilitate “live-in” care work, which involves migrant care workers living in their employers’ homes. Key among them is the live-in caregiver program (LCP) that ran from 1992 to 2014 and employed thousands of migrant care workers.

The LCP was made up of nearly all women between the ages of 20 to 40 (Kelly et al., 2011) and almost 95% of women were from the Philippines (Drolet, 2016). While migrant care workers fill the Canadian care deficit, the well-being of these women’s families often suffers in a multitude of ways because they are away from their loved ones for significant stretches of time, as long as ten years or more in many cases. How families experience these transnational relationships and the effects they have on children, spouses, parents, and other extended family is often unexplored. How do the women at the heart of these global networks manage their physical and emotional health while balancing the care work for their employers?

These implications of the LCP are rarely reported on in mainstream media and have received insufficient attention in scholarly research, which contributes to the silence surrounding these pressing issues of health, labour, and the gendered care economy. The broader geo-political context that informs the migrant women's labour journeys, which includes complex labour and migration regulatory frameworks among the countries that send care workers and those that receive them, is also under-explored. This study was designed to examine these critical issues from the perspectives of the women themselves, to learn more about what it means for migrant care workers to care for others while their ability to receive care from or provide care for their own families is constrained.

This dissertation is a critical ethnographic study that responds to and provides valuable insights about these pressing policy and health care issues. Specifically, I examine the health experiences of women migrant care workers from the Philippines who live and work in the Greater Toronto Area. Among the key issues I explore is how the physical, emotional, and mental health of migrant care workers is impacted by the structure of the previous LCP and the occupation of care work, both of which are highly gendered. A secondary aim of the study was to identify how multi-scalar policy, political, and geographic forces influenced women's decision-making and the strategies they employed to manage their health.

Situated within the critical theory paradigm, the study design was informed by global care chain theory and postcolonial frameworks throughout data collection and analysis, which allowed me to better understand how women managed their health and well-being in the face of competing responsibilities between Canadian employers and their families back home. I conducted the majority of the data collection activities within the Greater

Toronto Area, and also undertook three months of fieldwork in Manila, Philippines. Primary data collection activities included migrant care worker interviews (n=26), key informant interviews in Canada (n=9), key informants interviews in the Philippines (n=12), and content analyses of immigration new and policy documents (e.g., government press releases, policy briefs and reports). I also engaged in intensive, ongoing participant observation for several years and recorded field observations during my volunteer work at a drop-in centre for migrant care workers, ongoing community involvement with advocacy groups organizing for health care access for migrants, and attendance at forums and conferences related to health, gender, migration, and care work. Among the many compelling and pressing issues I focused on, trying to better understand how care policies impacted the lives and health of migrant women, who are excluded from full labour rights and protections because of their work and migration status, was central.

This chapter begins with an overview of the research objectives, which is followed by a discussion of migrant care workers programs in Canada, and the transnational legal and occupational frameworks that govern migration and recruitment of migrant care workers. I then address the significance of the research and how these findings from the study may inform the development of more gender and culturally appropriate policies that promote the health and well-being of migrant care workers. Finally, a description of the thesis chapters is outlined.

1.2 Research purpose

Migrant care workers from many countries have been immigrating to Canada under various federal programs to meet the intimate care needs of Canadian families since the

1940s (Stasiulis, 2012). In comparison to other forms of industrial, agricultural, and service-related labour migration programs, intimate care migrant care work typically takes place in clients' private homes, in which they may also live, presenting unique occupational challenges, such as long working hours, sleep deprivation, lack of privacy (Carlos & Wilson, 2018). The distinct gendered composition of those in the LCP, made up of 95% women, also demonstrates the enduring feminization of care work. As a Filipino woman whose family immigrated to Canada through previous opportunities for family sponsorship, I grew up knowing about this aspect of my community's immigration and occupational experience. As a feminist and health scholar, I seek to interrogate the intersecting vulnerabilities related to socio-cultural isolation and familial separation, both of which produce health disparities among migrant care workers. I designed this study to shed more light on these pressing issues, especially those related to gender and other intervening factors that position these migrant workers as precarious and vulnerable players in the global care chain.

The following questions were created to facilitate my research goals:

- How have changes in the LCP policy impacted the transnational migration experiences of Filipino women migrant care workers?
- How do the women navigate and juggle the competing occupational needs of their Canadian employers and the socio-economic and/or health needs of their families at home in the Philippines?
- Within the context of transnational migration and employment, what kinds of health needs and challenges do the women experience and how do they address such needs and challenges?

1.3 Relevance to existing research

The qualitative literature and grey literature, including policy and advocacy reports, on the LCP focuses on how the precarious status of migrant care workers produces conditions of vulnerability that are maintained through specific features of the program. Existing research on the health of temporary labour migrants has largely examined experiences of workers in the Seasonal Agricultural Workers Program (SAWP) and specific occupational health hazards they encounter (Edmunds et al., 2011; Hennebry et al., 2015; Nakache, 2012). While also a TFW program, the distinguishing features of the LCP, as one made up of predominantly women and whose work occurs in the private sphere of the home, presents unique concerns to migrant care workers' health because of the isolation they face, lack of workplace oversight, and the complex conditions their clients may have. Migrant care workers' temporary status can have complex effects on their health experiences, such as producing feelings of vulnerability and anxiety because of their exclusion from full labour rights protections under the law and access to various settlement services. The experience of this vulnerability and its consequences for migrant care worker's health and well-being has received significantly less attention.

Previous studies have noted that the health status of women who were in the LCP has the potential to become compromised due to their social, cultural, emotional, and geographical isolation (Spitzer & Torres, 2008). The isolation experienced by these women is compounded as their employer's homes constitute both their workplace as well as their living environment. Lack of control over their working conditions, including working hours and wages, as well as their living situation, have also contributed to stress and health decline (Vahabi & Wong, 2017). While 63% of those in the LCP had a

bachelor's degree or higher (a much higher proportion than other immigration categories) (Kelly et al., 2011), the experience of deskilling and downward social mobility has also been found to reinforce alienation among women in the LCP (Vahabi & Wong, 2017). Women have described feelings of shame, despair, and declining self-esteem over their downward social mobility (Vahabi & Wong, 2017).

Loneliness and depression as a result of family separation has also been documented across studies (Arat-Koc, 2006; Carlos & Wilson, 2018). Due to stress from work responsibilities, combined with feelings of isolation, women have also reported health concerns, such as chronic stomach pain, muscle tension, sleep problems, and frequent headaches to severe anxiety and depression (Arat-Koc, 2006). Studies have also noted the hesitancy of women to share their experience and challenges in Canada with their families back home from fear of causing them distress or pain as well as a reluctance and sense of shame of their hardship (Vahabi & Wong, 2017). In addition to feelings of ambivalence towards family as a social support, feelings of guilt and grief from being separated from their families are complicated by the pressure to send money back home (Vahabi & Wong, 2017).

Most research on migrant health and the health of TFWs in Canada has investigated how precarious immigration status and working conditions produce conditions of heightened vulnerability, which can have negative health consequences for migrant workers (Hennebry et al., 2015; Salami et al., 2015). These studies contribute important insights to understanding the health of temporary migrant workers in Canada, but limited studies examine the specific health challenges of migrant care workers. Further, workplace exploitation has been well documented in previous research on the LCP, however, studies

have paid less attention to how structural features of the program, such as closed work permits and temporary immigration status, influence women's health. I aimed to address this research gap by examining how women's health was influenced by the demands of their work responsibilities, along with the complexities of maintaining transnational familial relationships. I also address how the temporary immigration status of migrant care workers, the possibility of permanent residency, and delays in permanent resident application processing times has significant effects on mental health as migrant care workers experience anxiety, continued exclusion from health and social services, prolonged separation from their families.

1.4 Key changes to migrant care worker programs in Canada

Formal recruitment of foreign workers for domestic labour through Canada's immigration system began with the migration of Caribbean women in from the mid-1950s into the 1970s (Arat-Koc, 2006; Bakan & Stasiulis, 1996). The live-in caregiver program (LCP) was established in 1992 and lasted until 2014 and was designed to facilitate the recruitment of migrant care workers to provide care for children, the elderly, and those with high medical needs (Banerjee et al., 2017; Bhuyan et al., 2018; Spitzer & Torres, 2008; Straehle, 2013; Tungohan et al., 2015). After 24 months of service, migrant care workers would be eligible to apply for permanent resident status. As part of Canada's temporary foreign worker programs, the LCP provided a unique opportunity to pursue permanent residency (PR) and subsequently, the ability to sponsor family for permanent Canadian immigration. The promise of PR status was a unique feature of the program that enticed thousands of Filipino women each year. From 2005 to 2014, 31 859

migrant care workers held a work permit each year, yet only an average of 5540 became permanent residents each year (Drolet, 2016). Processing time estimates for permanent resident applications following the LCP ranged from 36 months (Bhuyan et al., 2018) to 48 months (Drolet, 2016).

In October 2014, major reforms were made to the LCP, and among the most significant was the removal of the live-in requirement and the guaranteed pathway to PR. Renamed the Caregiver Program (CP), the former LCP was replaced by the creation of two pathways, one for child care and one for those with high medical needs with PR admissions capped at 2750 for each pathway (Banerjee et al., 2017). To qualify for PR under either of the newly established CP pathways, migrant care workers needed to complete two years of care work in Canada, demonstrate Canadian work experience, one year of post-secondary educational credentials (attained in Canada or equivalent abroad), and higher English or French proven competency (CLB Level 5 competency required, increased from level 3 under LCP) (Caregivers' Action Centre et al., 2020). From 2014 to 2019, workers were not required to live-in with their employers, however, most had no choice but to continue doing so due to low wages and the high cost of living. While the removal of the live-in requirement was a welcomed change, critics highlighted how the removal of the guarantee to PR destabilized the notion of entitlement to live in Canada (Faraday, 2014). With the introduction of the CP, those in the former LCP had until June 2019 to apply for PR.

From June to October 2019, the Interim Pathway was created for a brief period for migrant care workers in Canada who had completed 12 months of work (instead of 24) to apply for PR with lowered educational requirements to the equivalent of Canadian high-

school credentials and the same increased language requirements from the CP. Since June 2019, the Home Child Care Provider Pilot and Home Support Worker Pilot has continued. Under the Pilot programs, workers arrive in Canada with an occupational work permit after preliminary processing of their PR application, if they have a guaranteed job offer. Family members of workers are also allowed to accompany them to Canada on their own work or study permits. Migrant care workers must remain employed in either child care or as a home support worker (without switching sectors) for 24 months before becoming eligible to apply for PR (Caregivers' Action Centre et al., 2020). Since the Pilot programs were introduced, advocates have continued to call attention to the restrictive nature of the increased educational and language requirements for both migrant care workers as well as their family members (Panlaqui & Rajesekar, 2021). Frontline workers in the community have shared stories of migrant care workers having less time to study for the language test because they have been increasingly surveilled by employers since the COVID-19 pandemic, while others have taken the language test as many as five to ten times, which has also been costly (Panlaqui & Rajesekar, 2021). Due to the recency of the changes, I did not speak to anyone directly affected by the CP or Pilot programs. At the time of data collection, many women I spoke with in the field shared that given the option of applying through the LCP or CP, they chose to apply through the LCP because they felt the language test requirements would be too high for them.

1.5 Demographics of migrant care workers in Canada

Given that all the women who took part in the study worked under the former live-in caregiver program (LCP) and the CP was a brief program, of which there is limited data or research, my focus throughout the project was the LCP. Previous studies on the LCP estimated women in the program were on average 34 years old with 84% having attained a university degree or higher (GATES, 2014). Extended family separation was a special concern among participants given that 67% of these women had children (GATES, 2014). Processing times for permanent residency, which averaged 26 months in 2013, significantly added to the cumulative time away from families for women (GATES, 2014). For many women, Canada was not their first destination for labour migration and their total time separated from family ranged from five to ten years, contributing to feelings of isolation, depression, and poor mental health (Vahabi & Wong, 2017). In another study by Banerjee et al. (2017) on changes to Canada's LCP, survey data found that 68% of respondents worked in a third country before arriving in Canada, while 14% worked in two countries before arriving in Canada. Overall, the most common path to migration was through Hong Kong (35%), followed by Taiwan, and Singapore (Banerjee et al., 2017). Occupational mobility for migrant care workers has also been limited as 68% remain working as caregivers three to five years after leaving the program (GATES, 2014).

Canada is increasingly reliant on temporary foreign workers (TFWs) to fill labour shortage gaps, increasing seven-fold from 111,000 in 2000 to 777,000 in 2021 (Statistics Canada, 2022). By 2009, the Philippines became the second or top single source country of immigrants to Canada (Kelly, 2014). Almost 60% of immigrants born in the

Philippines are women, a large number of whom came to Canada under the LCP (Yssaad & Fields, 2018). Internationally, Parrenas (2008) notes, “Migrant Filipina workers constitute one of the largest contemporary migrant groups, yet their experiences remain marginal in current theorizations of gender and migration” and “Care work is now one of largest exports and sources of foreign currency” (p. 30). Interrogating how gender as well as different axes of difference shape the experience of labour migration, and in turn, how this affects women’s well-being is imperative as both sending and receiving countries continue to benefit from the work of these women.

1.6 Study significance

In recent years, the government of Canada has continued to rely on exponentially more temporary foreign workers to address Canadian labour needs, including care work. Following the restructuring of several iterations of migrant care worker programs, Canadian families continue to benefit from the facilitated recruitment and work of women from overseas. As educational and language requirements for permanent residency continue to increase under current Pilot programs, women continue to face extended precarity. Findings from this study contribute to better understanding how the vulnerability of women in migrant care worker programs continues to be produced with both short and longer term consequences for their health and their families’ well-being. Migrant care worker programs continue to evolve, and migrant women have continued to help a growing number of Canadian families meet the care needs of some of the most vulnerable Canadians, yet they are denied care and reunification with their own families. The study’s findings contribute to literature, policy, and advocacy work calling for

multisectoral collaboration across policy levels to protect the health and well-being of migrant care workers who provide essential care.

The transnational perspective undertaken in this study has provided important insights into the global consequences of transnational care systems. The pathway to migrant care workers programs in Canada has become increasingly difficult to navigate with heightened requirements for work experience, education, and language testing. Given both the complexity and difficulty of navigating the application requirements, along with accessing Canadian employers, I found that migrant care workers increasingly rely on private recruiters to access the Canadian labour market. Left largely unregulated, private recruiters operating within Canada exacerbated the vulnerability of migrant care workers upon their arrival and throughout their time in the LCP. My research also adds new data on how the policies of the LCP and the transition to permanent residency can substantially extend the precarious immigration status of women with significant consequences for their mental health as well as the well-being of their families. My data also adds new insights on how care deficits and transnational motherhood connect and shape the relations of families who are separated by time and space, yet intimately bound together.

1.7 Thesis outline

In this first chapter, I have provided a description of the study's key issues of focus, including how migrant women's health is influenced by familial relationships and experiences of isolation, how these issues shaped the theoretical approach and design of the study, followed by an overview of recent changes to Canadian caregiver programs. In Chapter Two, I review the relevant literature on migrant care work globally and in

Canada, including international perspectives on foreign domestic work and Canadian migrant care worker programs. The focus is largely on Canadian research on the broad influence of temporary foreign worker (TFW) programs on migrant health, linking the precarity and vulnerability produced by the structure of TFW programs with the unique physical, psychological, and emotional occupational demands of intimate care work.

Chapter Three provides an overview of the research methodology and methods used for the study. I begin by discussing my ontological and epistemological positions and then describe my methodological approach using ethnographic methods throughout data collection activities across field sites in the Greater Toronto Area and Metro Manila in the Philippines. I also discuss how I conducted my thematic analysis and wove global care chain theory and postcolonial theory into my interpretation of the study data. Lastly, I share ethical considerations encountered throughout the study.

Chapter Four presents findings on the pathways through which women learned about the LCP, met the eligibility requirements, and navigated complex bureaucratic immigration admission regulations to go to Canada. The divergent outcomes and longer term consequences of these processes is then discussed. Chapter Five outlines how structural features of the LCP contributed to occupational health and safety hazards. I discuss the factors contributing to unsafe working conditions as well as how different types of care, specifically elder care and child care, can give rise to different occupational challenges. Chapter Six presents findings on the considerations of migrant care workers when deciding if and when to seek medical care, as they manage competing responsibilities between their Canadian employers and families back home. I also present findings on the

unique challenges impacting women's mental health as they perform intimate care work while being apart from their own families.

Chapter Seven synthesizes the findings in relation to the relevant literature on the key issues explored. This discussion addresses five main issues: unregulated private recruiters, long-term consequences of illegal recruitment, employer-tied work permits producing exploitative working conditions, the extended precarity for migrant care workers after completion of the LCP, and constrained family relationships. I then highlight areas for future research as migrant care worker programs in Canada continue to evolve. Finally, I reflect upon my position as an insider-outsider researcher and conclude with the contributions of this research to gender, migration, and care work studies.

Chapter 2

2 Synthesis of literature

Due to intersections of gender, race, migration, globalization, economic disparities, and the strains of gendered work, such as care work, migrant women care workers carry an unfair burden (Chen, 2017; Edmunds et al., 2011). How and to what extent migrant care workers coped and maintained one's sense of well-being, in the face of physical, mental, and social stressors, was a central focus of this research project. Access to social determinants of health, particularly one's living and working conditions, along with access to health services, undeniably impacts one's perceived level of control over their health and well-being. Oxman-Martinez et al. (2005) described how the precarious immigration status of women produced multi-level challenges, ranging from structural, systemic, and socio cultural barriers when accessing appropriate health services. By distinguishing the multiple barriers women with precarious status may face, Oxman-Martinez et al. (2005) also demonstrated how various impediments to care may exacerbate the other.

There is increasing attention across the literature on the effects of migrant care work on women's health around the world. In examining migrant care workers' experiences of health throughout the different stages of migration, Zimmerman, Kiss, and Hossain (2011) examined the cumulative effects of labour migrations on one's health, resulting in a higher risk for health complications that women and low-skilled migrant laborers may face. The study (Zimmerman et al., 2011) highlighted the need for these experiences to be contextualized across settings and outlined various stages of migration, including previous labour migrations, pre-departure, in the host country, interception, and

potentially upon return. The World Health Organization (WHO) (2017) report *Women on the Move: Migrant, care work and health* described “the care paradox” (p. 9) wherein immigrant women leave a deficit of care in their home country to work in informal settings within receiving economies, without full access to social protection and labour rights, while contributing to receiving countries’ health systems through providing essential care and health care services. The report provides an overview of the acute deficits of care services experienced globally across states that lack adequate public provision for long-term care, childcare, and care for the sick, and how this critical gap in services continues to be filled by women migrant care workers (WHO, 2017). Literature examining specific health conditions resulting from involvement in care work is also growing. Most commonly, the physical effects of care work are cited, including fatigue, hunger, falls, and muscular-skeletal strains and injuries caused by heavy lifting (WHO, 2017). There is also increasing attention in the literature on the mental health of migrant women care workers.

In recent years, there has been recognition of the evolving methods and procedures for knowledge synthesis and reviews (Kastner et al., 2012; Pluye et al., 2016; Whitemore et al., 2014). The synthesis of literature below was gathered through a general review process (Pluye et al., 2016), as I worked between ideas, themes, and theories. Research and grey literature relevant to my primary research questions were explored to better understand concepts and theories related to care work, gender, migration, and health, as well as the nature of studies related to the LCP specifically. Below I highlight current research on migrant care work internationally, the Canadian live-in caregiver program (LCP), followed by a closer examination of how structural features of the LCP shape

women's working and living conditions, exclusion from health and social services, the consequences of bureaucratic delays and policies on mental health, and finally long-term outcomes on health and well-being following the completion of the LCP.

2.1 Migrant care work

2.1.1 International perspectives on migrant care work

The global movement of care labour received increased attention in the 1980s as Saskia Sassen (1998) began to describe the flow of migration to global cities in order to provide various forms of reproductive work. By the 1990s, Arlie Hochschild (2000) articulated what she described as the global transfer of the services to meet care deficits experienced by industrialized countries. Over the past thirty years, as the international migration of women from the global South to perform care work has increased exponentially, international literature on migrant domestic work and care work has expanded markedly (Sarti, 2014). In all societies, there is a cultural preference for “ageing in place”, which has intensified throughout the COVID pandemic, despite the lack of statutory oversight in most home-based care settings (p. 9, WHO, 2017). Globally, fewer than 15% of home-based care workers are formally employed (Scheil-Adlung, 2015; WHO, 2017). Recent research across regions have identified shared challenges among foreign domestic workers (FDWs) due to the nature of domestic care work as well as strategies for resistance and providing transnational care for their families back home. Centering the care needs of migrant care workers and examining how they manage their own health, despite the structural forces on their lives and work, has received less attention.

Studies across Asia (Oishi, 2005; Parrenas, 2005), Europe (Anderson, 2000; Lutz & Palenga-Mollenbeck, 2012), and the United States (Hondagneu-Sotelo, 2001; Parrenas, 2008) contend that the position of migrant care workers is characterized by the two common aspects of their immigration status either being tied to their employer or being undocumented. Immigration status continues to play a key role in facilitating transnational care systems and an increasingly important dimension of inequality (Hondagneu-Sotelo, 2001). The racialization of migrant care work is thus seen as supported and perpetuated by the state (Anderson, 2000) because of its complicit role in the structural exploitation of the labour of women from the global South. The recognition of domestic work and care work as employment is often limited due to the private site of the household as the place of work. Legislation across jurisdictions is often regarded as ambiguous, offering migrant care workers minimal work protections. Arat-Koc (2006) makes a key distinction between the limited regulation of the working conditions of migrant care workers, while the workers themselves face increased regulations and restrictions on the terms of their work, status, and mobility.

2.1.2 Canada's Live-In Caregiver Program

Canadian literature on the live-in caregiver program (LCP) is extensive (Arat-Koc, 2006; Bakan & Stasiulis, 2012; Bhuyan et al., 2017; Bourgeault et al., 2010; Fudge & Parrot, 2013; Pratt, 2004; Spitzer & Torres, 2008; Spitzer, et al., 2003; Straehle, 2013; Tungohan et al., 2015) and highlights the gendered and socioeconomic dimensions of the work, integration, and settlement of women who participate in the program. Canadian literature on the LCP has highlighted the key barriers that have contributed to the limited occupational and social mobility of migrant care workers during the program and the

lasting consequences of this as they transition into permanent residency, and throughout long-term settlement.

While in the LCP, the inherent temporary status of migrant care workers produces conditions that leave migrant care workers in increasingly precarious work environments. Research has emphasized the problematic nature of having migrant care workers' work permits tied to a single employer, rather than the sector or type of work, because of the stark power imbalance created in favor of employers. Canadian employers are left unregulated without any governing body overseeing or enforcing labour contracts. The geographical and social isolation experienced by migrant care workers in such private work has also warranted concern over how this makes women more vulnerable to labour abuses as well as violence, which has been further exacerbated through the COVID-19 pandemic (Caregivers Action Centre, 2020). From an international perspective, Bakan and Stasiulis (1996) argue that, "the LCP appears as favourable policy only because the conditions of domestic workers on a world scale are so universally oppressive" (p. 220). Across the global care economy, Canada remained the only state offering the promise of permanent residency under the LCP as a unique opportunity that drew thousands of women from around the world. Below I highlight structural features of the LCP that give rise to health inequities that migrant care workers in Canada experience.

2.2 Structural violence of the LCP

There is a growing body of Canadian literature calling attention to how the increasingly complex Canadian immigration system is quickly becoming made up of more stratified categories through which people immigrate to Canada, with each category given differential rights to stay, work, and/or study in Canada (Fudge, 2011; Goldring et al.,

2009; Valiani, 2009). Of these groups, temporary residents (e.g., international students) and particularly temporary foreign workers (TFWs) are described as having “precarious legal status” defined as “the conditionality of one’s presence and access to services” because they do not have citizenship or permanent residency in Canada (para 1, Gagnon et al., 2021). The literature has recognized precarious immigration status (Bhuyan et al., 2018, Gagnon et al., 2021; Hennebry et al., 2015) in Canada as a determinant of health because of the potential health consequences that the conditions of their precarity produce. The specific policies that shape the LCP have been described by Bhuyan et al. (2018) as structural violence because of the way the policies shape migrant care workers’ response to workplace abuse and exploitation, such as long working hours and unpaid wages.

2.2.1 Precarious immigration status as a determinant of health in Canada

How one enters Canada, the migrant category through which one is admitted, and the immigration status they maintain has been recognized as an important social determinant of health throughout Canadian migrant health literature (Castaneda et al., 2015; Chen, 2017; Gagnon et al., 2021; Magalhaes et al. 2010). Studies on distinct groups of TFWs in Canada, including immigration streams for Lower-Skilled Occupations and Seasonal Agricultural Workers Program (SAWP) (Hennebry et al., 2015), have described the distinct effects that occupying liminal spaces has had on TFWs’ health and precarity. Literature on the health and safety of agricultural TFWs (specifically those in the SAWP) has been substantial, yet a focus on how gender influences the health of TFWs is limited. Oxman-Martinez et al. (2005) describe the intersection of federal immigration policy and

provincial health care policy as “an inherent double bind” (p. 253) that produces barriers that influence the health of women with precarious status in Canada.

Women performing care work in Canada as TFWs face unique health concerns characterized by their precarious immigration status, isolated workplace in private homes, and the highly gendered nature of care work. Caregivers continue to also negotiate their liminality as their rights and entitlement to health and social services are shaped by conditions of temporariness as they remain in constant flux moving between different employers, work permits, and can transition from temporary to permanent immigration status or lose status altogether. While women’s health is characterized by the precarity of their working conditions and immigration status, it is also strongly influenced by gaps in health care policy that limit their health care coverage eligibility creating unique challenges to accessing health services.

2.2.2 Employer-tied work permits as a deterrent from leaving poor working conditions

For TFWs broadly, the terms and recognition of their immigration status are fundamentally dependent on securing and maintaining an offer of an employment from an employer who acts as their sponsor to enter and stay in Canada. Prospective employers must apply to hire foreign workers by meeting certain income requirements as well as receiving a positive Labour Market Income Assessment (LMIA) that verifies no Canadian can do the job. Women in the LCP required a job offer from an employer approved to hire foreign workers (i.e., with a positive LMIA) in order to secure a work permit, which states they will only work for this specific employer, known as an “employer-tied permits” or “closed permits”.

Women in the LCP are strongly deterred from leaving poor working conditions given the time, difficulty, and cost of getting a positive LMIA that few prospective employers are willing to expense. For those that undertook to get a positive LMIA, the process took an average of four months, plus an additional four months to process a new work permit (Bhuyan et al., 2018). In total, women in the LCP who needed to change employers waited an average of eight months for a new work permit, during which they can be forced to work “under the table” survival jobs, leaving them vulnerable to losing their immigration status, without the work counting towards the 24-month work requirement (Bhuyan et al., 2018).

The “impossibility to find a replacement job” (p. 11, Vahabi & Wong, 2017) produced significant fear of job loss that could lead to repatriation, lost income, homelessness, and lost time to complete the LCP, along with prolonged separation from family. In a study on the mental health of live-in caregivers in Canada, Vahabi and Wong (2017) explained how the lack of labour rights protection gives implicit power to employers and women lived in “constant fear” of losing their livelihood as well as that of their families back home, who also relied on their financial support. The study highlighted how employers were aware of the 24 months of work requirement for PR and the women’s “desperation for permanent residency and family reunification” (p. 11, Vahabi & Wong, 2017). The difficulty of leaving poor working conditions and finding a new employer was only made more impossible during the COVID-19 pandemic (Caregivers’ Action Centre, 2020).

2.2.2.1 Working conditions

The structural conditions of the LCP produced specific working and living conditions that shaped the health of women, including their physical, mental, emotional, and social well-being. Employment and Skills Development Canada (ESDC) outlined the minimum requirements and guidelines for safe and fair living and working standards, however, the enforcement and oversight of such protections have been historically criticized for failing to ensure the same quality of living and working conditions for TFWs as that of Canadians (Bakan and Stasiulis, 1997; Fudge, 2011; Spitzer & Torres, 2008; Walia, 2010). Women in the LCP were both financially and legally dependent on their employers, leaving them vulnerable to workplace abuse. Research on the LCP has long cited specific workplace abuses, including physical harm (e.g., physical and sexual acts), psychological harm (e.g., verbal threats, emotional abuse), deprivation of basic needs (e.g., privacy, nutrition), and exploitation (e.g., unpaid wages, labour intensification, long work) (Arat-Koc, 2006; Bhuyan et al., 2018; Caregivers Action Centre, 2020; Tungohan, 2019; Vahabi & Wong, 2017).

2.2.2.2 Living conditions

Despite the removal of the live-in requirements under current Caregiver Pathways, migrant care worker wages often do not meet the cost of living in many Canadian cities. Living with employers under the LCP requirements contributed to the psychological burden of migrant care workers because of the lack of privacy and freedom, food insecurity, sleep deprivation, and at times sexual harassment from employers or other family members in the home (Bhuyan et al., 2018; Carlson & Wilson, 2018; Vahabi & Wong, 2017). Several studies have described the negative mental health effects of living-

in with employers, describing the lack of privacy as limiting their freedom, with some women reporting being under “constant surveillance” (p. 5, Vahabi & Wong, 2017) or “constant arguing” (p. 121, Carlson & Wilson, 2018) without social boundaries.

Inadequate food, inability to eat, and a worsening diet have also been described as a symbolic form of violence, exacerbating stress and poor health (Bhuyan et al., 2018).

Sleep deprivation and excessively long work days were also reported by women caring for elderly clients (Carlson & Wilson, 2018). Sexual harassment, such as being groped or having an elderly person they were taking care of kiss them, have also been outlined in the literature as contributing to unsafe living conditions (Bhuyan et al., 2018). During the COVID-19 pandemic, control over housing and movement also worsened as reports found women being barred from public transportation and unstable housing (Caregivers’ Action Centre, 2020).

The role of spatial integration in migrant adaptation has also been highlighted in international research on FDWs. Literature on domestic work has examined the utilization of public spaces in Rome and Los Angeles (Parrenas, 2008) as well as the transformation of space in Hong Kong (Peralta-Catipon, 2009) as a gathering place for FDWs. Both studies aligned with Canadian literature on the LCP recognizing that while the worksite of domestic workers is within their employer’s home, they feel a lack of privacy living within their employer’s household. The use of public spaces as sites to exchange experiences was critical to their sense of community, however it reflected their liminal membership and peripheral status within the larger society (Parrenas, 2008; Peralta-Catipon, 2009).

2.2.3 Delays in application processing times as symbolic bureaucratic violence

Literature on migrant care workers and TFWs in Canada has also called attention to how TFW programs produce and extend conditions of precarity. For TFW programs broadly, employer-tied work permits deter TFWs from leaving poor working conditions and restricts their mobility to work for employers across the sector, until an employer initiates the process of getting a new work permit. These mandated bureaucratic procedures at any point of transition for migrant care workers increases their chances of losing status and delays family reunification. These periods are marked by stress and prolong family separation with profound impacts on the health and well-being of migrant care workers and their families as they await decisions determining the future of their families.

Women who completed the 24 months of care work under the LCP continued to navigate immigration policies and procedures in order to apply for a new open work permit, applying for permanent residency, including undergoing medical examinations and sponsoring families. During the period between submitting a PR application and receiving a decision or the 90-day period after a valid work permit expired, women had “implied status” when they could submit a work permit renewal or apply for an open work permit (Bhuyan et al., 2018). With implied status, women continued to be excluded from full rights and services, including provincial health care coverage.

The processing backlog of PR applications from those who completed the LCP received increasing attention in the literature as well as media as processing times grew from 2003 to 2021 (Caregivers Action Centre, 2020; Keung, 2021). In a 2017 study by Banerjee et al., migrant care workers who arrived in Canada before 2003 waited an average of 15

months, while those who arrived in Can between 2007 and 2010 waited over 21 months (Banerjee et al., 2017). In another 2018 study by Bhuyan et al., those who finished the LCP faced an average waiting time of 56 months. By December 2017, the processing backlog was estimated at 23 000 migrant care workers waiting for their PR application to be processed, down from 62 000 in 2014. (Bhuyan et al., 2018). The processing backlogs effectively delayed the rights of migrant care workers and their families to reunify as Bhuyan et al. (2018) explains how this is “normalized as an administrative burden”. Lapses of work permit processing due to administrative errors also caused those with implied status to lose their status altogether. The extended family separation faced by tens of thousands of migrant care workers who had no choice but to remain in a liminal state is characterized by Pratt (2012) as trauma of prolonged family separation with long-term negative impacts on the health of migrant care workers and their families’ well-being.

2.2.3.1 Extended family separation

The emotional, psychological, and physical effects of prolonged separation between migrant care workers and their families have received growing attention throughout the literature. The cumulative toll of extended family separation over multiple migration cycles was of particular concern (WHO, 2017) in international and Canadian research. As separation is seen as necessary for the economic survival of families, women’s emotional suffering from physical separation has led to feelings of homesickness, sadness, stress, anxiety, and depression (P. 121, Carlson & Wilson, 2018). The literature also highlighted how the emotional and psychological toll for migrant care workers can be heightened because their principal task is to care for others, while they are unable to be with their own families (Parrenas, 2008; Tungohan, 2019; WHO, 2017).

In Canada, women in the LCP often had prior overseas work experience ranging from one to sixteen years (Bhuyan et al., 2018). The feelings of ambivalence experienced by women migrant care workers in Canada was described by Edmunds et al. (2011) as “a paradox of hope and despair” (p. 76), as families come to terms with the trade-off of closeness with economic security. In a study on the mental health of women in the LCP, Vahabi & Wong (2017) also noted that the pressure to send money back home was particularly strong when loved ones were ill, but women could not be by their side to provide care. For women in the LCP, the sacrifice of women’s emotional and psychological well-being is motivated not only to provide for their families financially in the short-term, but also motivated by the long-term prospect of reunification and permanent residency in Canada for their families.

International literature on the impact of migrant parents on the restructuring of households has also grown in prominence (WHO, 2017). Particular attention has been paid to the shifting roles within families as women become breadwinners and men as well as older parents play a larger role caring for children (Pingol, 2001; Tungohan, 2020). Increasingly, the impact of family separation on the well-being of children is also receiving more attention (Caregivers’ Action Centre, 2020; De Leon, 2009; Kelly, 2015; Parrenas, 2005) as well as the challenges of family reunification (Bhuyan et al., 2020; Pratt, 2012; Tungohan et al., 2015).

2.2.3.2 Mental health and migrant care workers

While there is a growing body of literature in Canada on migrant health, there remains a paucity of research on the mental health of TFWs specifically. Recent studies on the mental health of women in the LCP have found that along with family separation, the

culmination of experiences, such as deskilling, loss and grief, shame, and stress from work responsibilities, contribute significantly to feelings of isolation and depression (Carlos & Wilson, 2018; Vahabi & Wong, 2017). Studies associated women's internalized suffering with depressive symptoms, such as insomnia, crying every night, shame, loneliness, and prolonged feelings of sadness (Carlos & Wilson, 2018; Vahabi & Wong, 2017). Family relationships were constrained not only by physical separation, but also the shame and reluctance to tell families about experiences of de-skilling as well as poor working and living conditions (Vahabi & Wong, 2017). Downward social mobility significantly reduced self-esteem, as women did not share their feelings with their families from fear of causing them distress or pain (Vahabi & Wong, 2017). Stress related to loss and grief of loved ones back home they could not be with also significantly impacted mental health (Vahabi & Wong, 2017).

Women held sociocultural beliefs and values about mental health that were important factors influencing their reluctance to disclose symptoms or stressors. In an exploratory study by Vahabi and Wong (2017) on the mental health of women in the LCP, understandings of mental health were most influenced by working and living conditions, including the subordinate and precarious positions they held in Canada, along with socialized beliefs and values. Participants neither used existing mental health services nor knew what services were available to them (Vahabi & Wong, 2017). In terms of accessing health services, cultural attitudes and values were found to be a determining factor in seeking care (Vahabi & Wong, 2017) as women instead focused on being in control of one's emotions and their ability to cope with stress. Other research has also demonstrated that while migrant care workers may have an informal network of support

to assist with coping, they appear to have limited access to and/or stigma linked to accessing more formal mechanisms of support for mental health (Carlos & Wilson, 2018). Factors promoting mental health and protective factors against stress for migrant care workers were also highlighted in the literature, including social support, community connectedness, and a sense of belonging (Vahabi & Wong, 2017). Despite the limited access to social support experienced by most migrant care workers, families back home, new friends in Canada, and faith groups were key sources of social support (Bhuyan et al., 2018; Vahabi & Wong, 2017).

2.3 Exclusion from health and social services

While immigration policies determine an individual's right to enter and stay in Canada, temporary foreign worker programs, such as the LCP, exclude TFWs' rights to social services and equitable health care (Oxman-Martinez, 2005). Several studies have pointed to precisely the precarious status of TFWs and migrant care workers as the mechanism through which they can be denied social services and access to health care (Stasiulis, 2020; Straehle, 2013; Spitzer & Torres, 2008; Spitzer et al., 2019). Women in the LCP, live and work for years in Canada taking care of some of Canada's most vulnerable people, while they are denied a social safety net of their own. Until they have permanent residency, migrant care workers are also denied entry into most government-financed immigrant settlement programs and services, such as free English-language classes and employment counselling (Banerjee et al., 2017).

2.3.1 Structural barriers to health care coverage

While Canada is touted internationally for its “universal” health care system, entitlement to health coverage remains reserved for residents, as defined by each province and territory. Structural barriers to accessing health and social services are a direct result of federal immigration programs and policies that exclude TFWs, such as migrant care workers (Bhuyan et al., 2018). In the provinces of Ontario, British Columbia, and Quebec, a three-month wait period exists for new permanent residents and most groups of temporary residents (except for those in the Seasonal Agricultural Workers Program) before becoming eligible for provincial health care coverage. Upon arriving in Ontario, women in the LCP (and subsequent caregiver pathways) are subject to a three-month waiting period before becoming eligible for publicly funded provincial health care coverage under the Ontario Health Insurance Plan (OHIP). Those who finished the care work requirements to apply for PR must undergo the three-month wait period again once they are approved and their families arrive in Ontario.

In Ontario, health cards are typically issued for the duration of the work permit, often expiring within a year, despite the mandated two years of work to be eligible for PR. To apply for provincial health cards upon arrival and for renewal, a work permit is necessary to provide as evidence of “OHIP-Eligible Immigration Status.” For any change of employer, a new work permit must be issued for the worker once the new employer has applied and successfully received a positive LMIA, taking on average four months to process (Bhuyan et al., 2018). Should a health card expire between jobs before a new work permit is issued, the worker becomes ineligible for OHIP. Upon completing the program, between applying for PR and receiving a PR decision, an open work permit is

issued. When applying to renew a health card during this time, the open work permit can then be used as proof of immigration status, however, the additional requirement of full-time employment often prohibits women who have completed the caregiver program from qualifying for OHIP because they often take part-time jobs, which are more accessible due to their limited Canadian work experience (Banerjee et al., 2017).

2.3.1.1 Ontario three-month waiting period

As previously discussed, newly landed PRs and most TFWs in Ontario, British Columbia, and Quebec undergo a three-month waiting period prior to becoming eligible for OHIP to determine their intention to reside in Ontario. The three-month wait period has been cited as a common challenge for new migrants (Bobadilla et al., 2016), including migrant workers, accessing health care in these provinces (Vahabi & Wong, 2017). For the provinces of Ontario, British Columbia, and Quebec where a three-month wait period exists, ESDC advises employers that they are responsible for providing private health insurance, although no legislation exists to hold employers accountable. While ESDC provides guidance to employers on providing private medical insurance during the waiting period and outlines examples of such provisions in example employment contracts for caregivers, the employer's duty is not stipulated in any legislation or policy, leaving caregivers without any avenue of recourse should they incur significant medical costs.

Awareness of the employer's responsibility to provide private medical insurance during this time was limited and for those who were aware, there remained no options to report or assert their right to health coverage (Carlos & Wilson, 2018). In a study by Carlson and Wilson (2018), only 5 of 21 participants reported that their employers provided third-

party health insurance during the three-month wait period, while 12 of 21 were not aware that employers were responsible for providing this health insurance. If a caregiver required medical attention during her first three months in Ontario, it became her sole responsibility to pay for care out-of-pocket.

The Ontario Ministry of Health and Long Term Care maintains that the three-month wait policy prevents medical tourism and deters people from coming to Ontario for the sole purpose of acquiring medical services. While the three-month wait policy rationale is to protect Ontario's health care system by warranting against medical tourism, women who complete the LCP and transition to PR lose health care coverage after working, living, and caring for residents of Ontario for over two years. During this time of transition, previous caregivers and their families are denied access to the very health care system they subsidized through their care work precisely once the documentation of doing this work and meeting all other requirements of the LCP is verified and their PR status is approved. The very structure of the LCP ensures women making the transition to PR status have maintained residency and paid taxes in the country usually for at least two years and up to over thirteen years in some cases. Due to the unpredictability of the PR application process, women's access to health care can be severely compromised simply because of the timing between temporary work permit or open work permit expiration dates, receiving PR, and consequently having to undergo the three-month wait.

2.3.1.2 Employer-mediated access to care

For women in the LCP, employers mediate access to health care coverage, health services, and time off to seek medical attention. Employer discretion determines everything from having a valid work permit to getting time off work to get medical

attention. Across the literature, studies demonstrated how it was problematic for employers to maintain disproportionate power over migrant care workers' access to health care. Studies noted that TFW's dependence on employers for access to health insurance, transportation, and time off work to seek care can deeply compromise their medical confidentiality in ways that can have implications for both their employment and immigration statuses (Hennebry et al., 2015). This was especially problematic for women in the LCP who lived with their employers with little privacy, at risk of jeopardizing their future application for permanent residency, or even be deported if they complained too much or were too sick to work (Oxman-Martinez, 2005). During the COVID-19 pandemic, migrant care workers also reported having their mobility further restricted by employers who forbid them from using public transportation or leaving their residence entirely from employers' fears that they could bring the infection back to their homes (Caregivers' Action Centre, 2020).

2.3.1.3 Health care avoidance

It was widely acknowledged across the literature that TFWs, including migrant care workers, avoided seeking health care from fear of losing their status (Bhuyan et al., 2018). The threat of losing immigration status was often greater than the perceived need for seeking medical attention. The vulnerability of women in the LCP was also magnified by the pressure to send money to families back home (Tungohan, 2019) as well as the pressure to complete the LCP in order to sponsor their families (Oxman-Martinez, 2005; Vahabi & Wong, 2017). Globally, it was also recognized that mandatory health testing both before and after migration also acted as deterrent from seeking care for migrant care workers (WHO, 2017). In Canada, women who completed the LCP have had their PR

applications rejected because of a life-threatening illness found during their medical examination for their PR application (Keung, 2008).

2.3.1.4 Limited awareness of rights and entitlement to services

The literature also highlights how social networks and access to information about worker's rights, navigating immigration processes and applications, and accessing health services are truncated because of the specific living and working conditions of women in the LCP (Banerjee et al., 2017; Bhuyan et al., 2018; Vahabi & Wong, 2017). Research has also demonstrated that a lack of knowledge or understanding about safe work practices, rights, and entitlement further compounded vulnerability to health risks and could also compromise access to care (Hennebry et al., 2015). Media and research have also reported that migrant care workers not only seek legal support to complete their PR applications, but they either pay expensive legal fees to do so and/or are victims of fraudulent legal representation (Bhuyan et al., 2018; Standing Committee on Citizenship and Immigration, 2017).

Social support was mediated by access to the Internet as well as faith and ethno-specific organizations that were key to engagement and information dissemination about employment rights, accessing health care, mental health resources, and community support (Vahabi & Wong, 2017). Importantly, recent research (Bhuyan et al., 2018) has also described how shame and stigma about performing care work can influence help-seeking behaviour, but family, friends, and social media continue to be important avenues for help and social support. However, the authors emphasize that information through informal networks could lead to dangerous misinformation (Bhuyan et al., 2018).

2.4 Long-term outcomes following the LCP

There is also a growing body of research on the long-term outcomes of the LCP examining issues related to deskilling, family reunification, and stigmatization (Atanakovic & Bourgeault, 2014; Lightman et al., 2022; Torres et al., 2012; Tungohan et al., 2015). Women previously in the LCP who were entering the formal Canadian labour market faced challenges trying to pursue educational upgrading because the costs were found to be prohibitive given existing pressures to continue to remit to their families back home. Remittance obligations limited women's financial ability to take time off to undergo training as well as pay for education and training (Banerjee et al., 2017). Women also reported significant financial and psychological stress following PR, as they prepared and tried to save for their family's arrival in Canada (Banerjee et al., 2017). Given this pressure, women often immediately entered low-wage jobs, acquired through informal networks, in order to afford sponsoring their families as well as save for training courses. Those who accessed loans were able to undergo training and find employment in lower paid health related jobs high in demand, most commonly as a personal support worker, as well as a dental assistant, resident care attendant, and early childhood educator (Banerjee et al., 2017; Torres et al., 2012). Canadian work experience as a caregiver was met with stigmatization by both potential employers as well as those within the ethnic community, limiting the support and job opportunities that were available (Tungohan et al., 2015).

2.5 Summary

The purpose of this literature synthesis was to outline current literature on migrant care work both globally and in Canada to better understand how temporary foreign worker

(TFW) programs, and specifically the live-in care program (LCP), has influenced the health of migrant workers in Canada. This literature provides important insights to consider in trying to better understand how the structure of the LCP influences the health of women participating in the program as well as their relationships with employers and their families. The first section of this chapter focused on international literature on foreign domestic workers across the US and Asia, then reviewed research on Canada's LCP specifically, highlighting the ongoing need for migrant care workers, along with long-standing concerns over the working and living conditions they have faced.

The second section of the literature synthesis examined how the structure of TFW programs in Canada produces precarity and has been well documented as giving rise to disparate working and living conditions for migrant workers, leading to significant negative health consequences. More recent literature has also called attention to the symbolic bureaucratic violence faced by migrant care workers after they completed the required 24 months of work under the LCP and applied for permanent residence status when they are faced with substantial delays in application processing times. These delays in processing times further contributed to extended family separation that had significant detrimental effects for the mental health of migrant care workers.

The third section highlighted how intersecting immigration and health policies have structured the exclusion of those in TFW programs from health and social services in Ontario. Federal immigration policies and programs together with provincial health policies produce structural barriers to health care, which has been highlighted across interdisciplinary research from the fields of health, migration, social work, sociology, law, and political science. In addition to the structural barriers to health and social

services, immigration policies that produced precarity for women in the LCP also served to deter them from seeking health care from fear of losing status as well as limiting their access to networks to support their awareness of their rights and entitlement to services. In the final section, I shared emerging research on the long-term outcomes of those who completed the LCP, including socioeconomic outcomes, integration and settlement, and family reunification. The insights drawn from this synthesis of literature will be considered as they relate to the theoretical frameworks presented in the following methodology chapter and throughout the findings generated from this study.

Chapter 3

3 Methodology and methods

3.1 Introduction

In this study I used critical ethnographic approaches to examine the health needs and challenges women in the LCP experienced throughout their experiences of transnational migration and in the face of their competing responsibilities between their Canadian employers and families back home. Data collection included observational field notes of settings and dynamics across participant interviews, at a volunteer site, community meetings, forums, and conferences. As well, individual interviews with women in the live-in caregiver programs (n=26) and key informants (n=21) across the Greater Toronto Area in Canada and Metro Manila in the Philippines were conducted. Global care chain theory and postcolonial theoretical frameworks were employed within thematic data analysis to understand the strategies women employed to manage their health and well-being while managing competing responsibilities across transnational spaces. This chapter examines the methodological positionings and theoretical frameworks employed in my study during data collection and analysis, along with the tensions that emerged among my participants and myself over the course of this complex, illuminating study that spanned from fall 2016 to winter 2018.

The study sought to explore how intersecting vulnerabilities, related to socio-cultural isolation and familial separation, may produce health disparities among migrant care workers by addressing the following the questions:

- How have changes in the LCP policy impacted the transnational migration experiences of Filipino women migrant care workers?

- How do the women navigate and juggle the competing occupational needs of their Canadian employers and the socio-economic and/or health needs of their families at home in the Philippines?
- Within the context of transnational migration and employment, what kinds of health needs and challenges do the women experience and how do they address such needs and challenges?

3.2 Ontology and Epistemology

Fundamental to critical ontological positioning is that all meaning is socially and historically mediated by power and objects become represented by signs and signifiers that are repeated and enforced over time (Kincheloe et al., 2005). Scholars who employ a critical approach are concerned with tracing the relationship between power and the object of inquiry and how it is represented or understood through interrogating the positionality of both the object and the researcher (Carspecken, 1996). Critical epistemology complicates our understanding of how power influences people's subjectivity within different locations by constraining or reinforcing truth claims of certain groups of people (Erickson, 2005). Truth claims are controlled and circulated through unequal power relations that constrain the possibilities of understanding of different groups. Strategies of knowledge and power then inhibit the potential meaning of signs and signifiers as well as the subjectivity of marginalized groups (Carspecken, 1996). By interrogating these understandings and the absence of knowledge of different groups, those who work from a critical epistemological position are committed to social change through problematizing how some marginalized groups have come to be represented and the implications of such representations for possible ways of sense making and acting in the world.

Those working from a critical epistemological framework question and resist the conditions that create unequal power relations by investigating how power becomes subverted. Such researchers are also often committed to social justice and as a form of inquiry, scholarship can be considered itself an act of resistance (Kincheloe, McLaren & Steinberg, 2005). The need to be explicit and aware, on an ongoing basis, of the power differentials between researchers and participants, is a central tenet for many practitioners who are committed to critical epistemology. Recognizing the co-creation of information and shared experiences during the research between researchers and informants is imperative in the praxis of reflexivity. By acknowledging that social relations are constantly shifting and evolving through this lens, I was able to develop a better understanding of how the social location of participants, and myself, can influence how we attributed meaning and value to our experiences.

3.3 Theoretical framework

3.3.1 Global care chain theory

The demand for migrant care workers, the feminization of migration, and the increasing complexity of global economies has led various researchers to conceptualize the global networks of care through the global care chain (GCC) theory (Fudge, 2011; Raghuram, 2012; Tungohan, 2019; Yeates, 2012). Global care chain theory was first introduced by Arlie Hochschild (2000) to describe how deficits of care within the home were created as more women in the North entered the workforce and migrant domestic workers from the South filled this deficit of care, but at the same time transferred it to their own families they left in the South. Migrants from poorer households in the rural South then moved to the urban South to fill the deficit of care within the international migrant's household,

with the chain often ending in poorer households in the rural South where non-waged family labour was depended on to fill the deficit of care that resulted from migration (Yeates, 2009; Kofman, 2012).

Using GCC theory has enabled my exploration of both local and transnational dynamics of care (Yeates, 2012) that contribute to the global market economy. Due to the diversity of labour that migrant care workers provide, Parrenas (2008) proposed that a more accurate description of the transfer of care work to labour migrants would be the “international division of reproductive labour”. The inclusion of GCC theory has allowed for the analysis of the different types of reproductive labour that migrant care workers provide across care settings (Tungohan, 2019). Different types of care, distinguishing between childcare, elder care, and those with special medical needs, the variety of domestic work beyond caring responsibilities that migrant care workers may have, and the settings/sites in which they work. For example, I was able to compare and contrast the different types of care work and/or health professional experience the women had in the Philippines and/or in previous countries. Further, GCC also afforded the opportunity to ask questions about the context of women’s familial caring responsibilities and how their family dynamics influenced the trajectory of their migration.

3.3.2 Postcolonial theory

Postcolonial theory seeks to unpack and problematize historical social inequalities resulting from colonial encounters and their ongoing effects on Indigenous and racialized nations throughout the globe. The inclusion of insights from a postcolonial framework, which enables the centering of the experiences of women across localities and multiple subjectivities, was necessary to deconstruct and contest essentialist nationalist discourses

as well as hegemonic representations of women outside the West (Spivak, 1996). Within such a framework, I had the opportunity to explore historical international relations that have given rise to current neocolonial conditions, and resulting transnational relations. As the Filipino diaspora continues to grow and intensify around the world, the rupture in national collectivity and cultural identity complicates the task and potential of decolonization (Lacsamana, 2009). For Filipino women, their multiple subject-positions also further problematizes the consolidation of their various identities and competing responsibilities. How women used their agency to navigate the structural barriers of the LCP and how this shaped their relationships with their families, employers, clients, as well as their health and well-being was a central focus of my research. The inclusion of insights from postcolonial theory enabled the exploration of how women framed their opportunities globally and strategized their pathway to Canada, including their expectations of working in Canada. Further, how their families' perceptions of Canada influenced their relationships, such as the support women received to go work in Canada or the pressure they felt to support their families back home while working in the LCP.

Working from a postcolonial framework facilitated the exploration of both the gendered and racial ideologies that were fundamental to national discourses, of both the Philippines and Canada, that perpetuated essentialized understandings of female national subjects for the purposes of the commodification of their labour and bodies. A key aim of this project was to examine the transnational facilitation of the importation of female migrant labour and the mutual interest of the Philippines and Canada in maintaining the flow of foreign domestic labour. Postcolonial theory bridged the investigation of marginality and the reinforcing relationship between the colonizer and colonized subjects. By maintaining

colonized subjects as marginal, value and “surplus”, they can continue to be derived and extracted from their labour (Spivak, 1996). Postcolonial theory served to connect gendered dynamics across transnational scales and sites, such as the home, communities, and families to larger historical socio-cultural, political, and economic structures.

3.4 Methodology

3.4.1 Critical ethnography

In this study I used critical ethnographic approaches to explore the lived experience of migrant care workers in relation to migration, work, and health and how transnational structural forces shape their daily health experiences. In line with critical epistemology, ethnography is also critical and interpretive (Erickson, 2005) and aims to describe and make sense of the culture and daily life of groups that share in a specific experience. The exploration of these relationships and shared practices of meaning making fundamentally assumes that meaning is never stable and is always emerging. Tedlock (2003) describes the ethnographic encounter as “intersubjective and embodied” (p. 183), from which a researcher can only derive partial meanings because of the multiple positions and identities that inform both the researcher and participants’ interpretations of the interaction. In investigating diverse social processes, ethnography affirms the value and meaning that marginalized groups attribute to their own experiences, working from their own description of phenomena and symbols. Through making visible the perspectives of marginalized groups, ethnography can be used to confront inequities and disparities in representation; thus making it both a political act and methodology (Erickson, 2005).

Ethnographic approaches were ideal for examining migrant care workers' lives as they move through and negotiate their identities within transnational sites and spaces over time. Critical ethnographic approaches consider people's identities as partial and emergent because they occupy multiple locations that are socially constructed and mediated by relations of power (Cook, 2005). As participants occupy multiple positions, critical ethnography was suitable for exploring their motivations for migration and how this informed their occupational and health behaviours, strategies, and decisions. This approach also helped me to be mindful of how I facilitated the interactions between myself and the participants in ways that allowed for the development of deeper understandings of the women's decision-making processes across various aspects of their life, particularly their family, work, and health. Ethnographic methods, such as observation and interviews, which are designed to capture the rich detail of everyday life as well as the broader socio-political and cultural contexts that shape how people experience and move through their respective life worlds (Foley & Valenzuela, 2005), were ideal tools to explore the complex relationships migrant care workers have with people and places, and how these figured prominently into women's lives and choices.

3.5 Data Collection

Data collection was conducted primarily in Canada, specifically the Greater Toronto Area (GTA) with some fieldwork done in Manila, Philippines with key informants. In total, I conducted 47 interviews across all fieldwork sites. Throughout the GTA, I spoke with 16 migrant care workers (n= 26 interviews), each taking part in two interviews, either individually (n=11), in a pair (n=2), or in a small group (n=3) (see Table 1). Fieldwork in Toronto also included participant observation and observational field notes taken at a

drop-in centre I volunteered at for approximately one year as well as during my participation in community gatherings, conferences, and meetings related to migrant workers, migrant health, the Filipino community, and care work. As well, 10 key informants took part in one interview each (n=9 interviews; one interview done with a pair of key informants)(see Table 2). Fieldwork in the Philippines included 12 interviews with 15 key informants (three done in pairs)(see Table 3), as well as fieldnotes from attendance at several forums, symposiums, and conferences related to gender, migration, and care. In addition, participant observation notes were taken across sites, participant groups, and interviews. Content analysis of key documents related to the Canadian and Philippines immigration policy, migrant care work, gendered labour migration programs, and migrant health was also completed.

Table 1: Breakdown of migrant care worker interviews

Interview set (2 interviews per set)	Participant	Pseudonym
1	1	Jessica
2	2	Jenny
3	3	Marlyn
4	4	Nicole
	5	Lisa
5	6	Mary
	7	Princess
	8	Ashley
6	9	Lita
7	10	Evelyn
8	11	Aura
9	12	Nenita
10	13	Gina
11	14	Patricia
12	15	Melissa
13	16	Carmela

Table 2: Breakdown of interviews with key informants in Canada

Interview	Key informant	Sector	Pseudonym
1	1	Non-profit community organization	Erich
2	2	Non-profit community organization	Etta
3	3	Non-profit community organization	Cora
4	4	Advocacy	Leah
5	5	Advocacy	Sasha
	6	Advocacy	Eddie
6	7	Advocacy	Paulo
7	8	Law	Katrina
8	9	Medicine	Robert
9	10	Government	Aurora

Table 3: Breakdown of key informant interviews in the Philippines

Interview	Participant	Sector	Pseudonym
1	1	Civil society organization	Larry
2	2	Civil society organization	Nora
3	3	Service provider	Bonnie
4	4	Research	Laura
5	5	Government health	Glen
6	6	Government	Roger
	7		Lovey
7	8	Research	Roxanne
8	9	Civil society organization	Victoria
9	10	International agency	Josh
	11		Jimmy
10	12	Private recruitment agency	Ryan
11	13	Government	Danny
	14		Zeny
12	15	Research	Isabelle

3.5.1 Data Source 1 – Migrant care worker interviews

Approximately half of Canadian migrant care workers arrive in Ontario (Salami, 2014), and as the primary destination of the greatest proportion of migrant care workers, recruitment was conducted in the GTA. Participant recruitment was done with neighbourhood and grassroots organizations working with the Filipino community and migrant workers based in Toronto. Working collaboratively with these community gatekeepers, I utilized purposive and snowball sampling to recruit the sixteen migrant care worker participants. The inclusion criteria for these participants included:

- being female
- having migrated to Ontario through the LCP from the year 2000 to present,
- fluent in English, and
- between the ages of 20 to 60 years old.

The 26 interviews that I conducted were undertaken with care and to accommodate participants' comfortability, two sets of interviews were conducted with two pairs of women (i.e., two participants during one interview and follow-up interview) who were friends and preferred to speak with me together (i.e., two pairs of participants took part in interviews together). Interviews were conducted in locations selected by participants to ensure they were accessible, participants felt safe, and to decrease the burden of participation by minimizing their transportation as much as possible. The women preferred to be interviewed in places that were familiar to them, such as public libraries, their homes, coffee shops, or community meeting spaces (e.g., church basement).

The semi-structured interviews were conducted in English, lasted between 60 to 90 minutes and were guided by a set of open-ended questions (see Appendix A) about the

women's migration stories. Utilizing a life history approach, the initial interview aimed to better understand the context of the women's lives, with respect to where they were from in the Philippines, previous occupations, and their family structure. I created space for women to focus and expand on matters of interest and significance to them, such as their families. During the initial interview, I also aimed to learn about their journey to Canada and current experiences working in Canada. A follow-up was done with all participants and were an opportunity to clarify or ask participants to elaborate on different events throughout their migration journeys, work experiences, how they perceived their current health and well-being, any health issues they continued to manage, as well as to what extent they sought help for any health concerns.

Participant observation notes taken during the recruitment process and interviews were a key component of data collection. I recorded dialogues and interactions between individuals at recruitment sites, in different settings and environments, as well as moments or events that held significance for migrant care workers. Participant observation was a critical part of this ethnographic study as it helped to identify and document how women contested, adapted, and coped with the occupational, interpersonal, and health challenges they faced. Both private and shared spaces reflected different ways in which women found community or were able to strategize living spaces that met their needs. Observation of these spaces and interactions within them were important and reflected the adaptive and coping mechanisms women used to create space for themselves outside of their workplaces as well as be part of different communities.

From the fall of 2016 until September 2017, I volunteered weekly at a support group drop-in centre for migrant care workers. With support from a local faith organization,

women currently working in the LCP as well as those who completed the LCP were invited to the centre to socialize, participate in organized activities, use a computer, or seek support from a neighbourhood settlement counsellor. The faith organization that supported the drop-in centre by providing a space to gather was made up of predominantly Filipino congregations, with signs throughout the property also available in different Filipino dialects. The drop-in centre was a place of reprieve for most women who lived with their employer and few spaces in the community where they could relax during their time off. A key feature of the drop-in centre was the flexibility women had to come and go as they pleased, participate in organized activities as they were interested, form friendships with people who shared similar experiences in the LCP, share food, use a computer, or take time to rest outside of the purview of their employer and in a safe place. Organized activities included art therapy, a tax clinic, pilgrimage trips, and seasonal prayer and faith traditions.

Informally, women shared stories about their employers, clients, application processing, finding housing, as well as connecting each other with potential employers. Women were also able to share important life milestones together, celebrating the achievements of their kids and families back home, or grieving the passing of family members. It was a safe refuge for women to exchange stories and information as well as share laughter and tears in a semi-private place they could feel more comfortable in. Women exchanged stories about families back home, children, recalling stories of pregnancy and marriage. They formed friendships and a small community trying to help one another get through the program. A couple of women who completed the LCP also returned to the centre proud to introduce their children and spouses once they arrived in Canada. Seeing other women

reunited with their families brought mixed feelings of joy, celebration, and a cautious optimism among the women. Notes and observations were taken following my volunteering each day.

As part of my field work in Toronto, I also attended community gatherings, conferences, and meetings related to Filipino migration, migrant workers, migrant health, and care work. For example, I was invited to attend two gatherings for different Filipino youth groups. Filipino youth who recently arrived in Canada or who were first generation attended these workshops to learn about the connection between the history of the Philippines export labour policy and the collective struggle across diasporas. During these workshops and discussions, the emotions felt by youth were visible as they shared stories of their family's sacrifices, their time apart, and their continuing struggle in Canada. Youth spoke of the years of separation they had from at least one of their parents working abroad when they were in the Philippines, only to be reunited in Canada, but not have time for each other as parents continued to work multiple jobs, usually doing shift work.

3.5.2 Data Source 2 – Key informants in Canada

In total, I conducted nine interviews with ten key informants across the GTA, including medical and social service providers, settlement support workers with community organizations, representatives of advocacy organizations for migrant workers, an immigration lawyer, and a Philippines consular representative. Speaking with this diverse group of stakeholders allowed me to develop a rich, holistic understanding of the political and socio-economic context that women in the LCP navigated throughout their time in the LCP and afterwards. One interview of approximately 60 minutes was conducted with

each key informant and one interview done with a pair. Key informant interviews were conducted and analyzed concurrently as both participants and key informants became available.

These key informants had a range of in-depth understandings of the unique health and gender-related factors that can influence the experiences of women in the LCP. My extensive, ongoing community involvement with grassroots migrant health advocacy groups allowed me to tap into networks of health, social service, and settlement organizations. Through establishing or building on relationships with organizers and providers working across these fields, I was also invited to take part in activities, workshops, or forums where I was privy to discussions between community members and stakeholders as they shared information, navigated services, and developed collective approaches to adapt to policy changes. During discussions, I took notes of key concerns and activities and following events, I wrote reflection notes about relevance to the study, issues of importance to different groups, my personal experience participating across different events, and any potential implications of my involvement (e.g., if the presence of a researcher produced discomfort).

3.5.3 Data Source 3 – Key informants in the Philippines

Fieldwork in the Philippines was supported by the University of Toronto Centre for Global Social Policy's Doctoral Associate Program with the *Gender, Migration and the Work of Care* project. As a doctoral associate, I was granted affiliation with the Visiting Research Associates program at the Institute for Philippine Culture at the School of Social Sciences in Ateneo de Manila University, which facilitates studies of Philippines culture and society by scholars from abroad. Through the affiliation, I was supported in

connecting with researchers, civil society organizations, government officials, health and social service providers, representatives of international agencies, and a private recruitment agency, culminating in a total of 12 key informant interviews.

Conducting my research in a transnational setting allowed me to gather a uniquely in-depth understanding of the broader global context of Philippines migration, including the regulation of Philippines emigration, priorities, and the growing recognition among government and civil society representatives to address the health needs and safety of overseas foreign workers (OFWs). Conversations with key informants as well as participant observation across locales, agencies, and organizational settings helped me to see the diversity of clients (e.g., across cities and regions, sectors of work, countries returning from or going to) served as well as the demand and range of services offered. I also developed a greater appreciation for the myriad challenges OFWs and their families faced trying to navigate bureaucracy and support across countries and/or throughout the Philippines. The class differences/resources at the disposal of families and OFWs hoping to work in particular sectors of different countries also contextualized the social and cultural backgrounds of migrant care workers in Canada given the intensive requirements of the LCP and caregiver programs. Through exploring both the social and structural dynamics of those implicated in the foreign domestic work economy, I was better able to elucidate the complex and nuanced processes and connections that tie together the broader care economies of both Canada and the Philippines.

From the airport, bookstore, to government agencies, there were clear signs of decades and generations of the Philippines labour export policy. Upon landing in the Philippines international airport, OFWs had a separate customs line to process their re-entry and

outside there were billboards greeting them, “Welcome back OFW seafarers.” On an early morning drive in the city past the Department of Foreign Affairs there was a line around the block before it even opened. At the mall bookstore, there were sections dedicated to a range of English and Arabic to Filipino dictionaries, along with another section solely for nursing exam guides and practice tests. People everywhere shared stories of working abroad, family abroad, or their current plans for finding work overseas. Meanwhile in the local news, the current administration’s “war on drugs” continued and stories of teens killed by police for alleged drug possession made headline news that grew more devastating as their mothers who were foreign domestic workers abroad returned home for their funerals. Also making headlines was the 1000 PHP (roughly \$20 CAD) government budget dedicated to the Commission on Human Rights (CHR), considered by CHR representatives as a “slap in the face” for the flags raised on the extra-judicial killings for the war on drugs. Finally, countries like New Zealand continued national recruiting efforts working with the POEA to announce hiring for 5000 jobs. Throughout this fieldwork, I took reflective notes on general observations, such as the types of institutions that were involved in the Philippines migration industry. For example, government agencies for OFWs and foreign affairs, training organizations, overseas labour agencies, international organizations, and civil society organizations (CSOs).

As I established relationships with a network of scholars, CSOs, and government officials during my time as a Visiting Research Associate at the Institute of Philippine Culture I was very fortunate to also be invited to forums, symposiums, and conferences related to gender, migration, and care. Participation at these events and activities provided insights into the position of the Philippines and global migration systems. These meetings were

incredible opportunities to learn about the perspectives of a wide range of stakeholders, including grassroots leaders, health and social service providers, international consultants, government officials, and researchers. During these events, I took observational notes throughout discussions as well as reflective notes following each activity. Reflective notes were also shared with my advisory committee throughout my time in the Philippines to provide preliminary insights on my fieldwork and data generated. Forums attended include:

1. Civil Society Organizations Consultation on the ASEAN Instrument of Protection and Promotion of the Rights of Migrant Workers hosted by the Philippines Commission on Human Rights (CHR) (September 26, 2017 at the Commission on Human Rights, Diliman, Quezon City, Philippines)
2. Civil Society-Private Sector Consultations on the Global Compact on Migration hosted by the International Organization for Migration (IOM), Blas Ople Centre, and the Development Bank of the Philippines (DBP) (October 5-6, 2017 at Makati City, Philippines)
3. Workshop on “Promoting the Well-Being and Financial Health of OFWs: Insights from a 3-year study” sponsored by the Asian Institute of Management (AIM) and OWWA (October 24, 2017, Makati City, Philippines)
4. 1st Southeast Asian Women’s Summit: “50 years of ASEAN: What’s in it for women and why women are in it?” (November 7-9, 2017 at Miriam College, Katipunan Avenue, Loyola Heights, Quezon City, Philippines)

Across the range of events I attended, there was a tension between the deployment and protection of OFWs. During consultations with CSOs for the ASEAN Instrument of Protection and Promotion of the Rights of Migrant Workers and the Global Compact on Migration, CSOs, advocates, and family members expressed profound disappointment after learning that neither would be legally binding. These advocates for migrant rights

lamented the labour conditions OFWs worked in abroad and spoke with frustration about the limited job opportunities at home. Speaking to different stakeholders, it became clear that the pursuit and maintenance of the middle- class lifestyle in the Philippines was strongly dependent on the remittances of one or more family members. In strong contrast to migration management in Canada, recruitment agencies were recognized as key players in global migration with representatives from the sector also invited to consultations and meetings. Recruitment agencies worked with training agencies, government, international employers, and prospective OFWs alike to broker and facilitate access to global employment contracts.

Conversations with government officials, CSO representatives, and grassroots leaders, made clear that the Philippines government migration management priorities focused on the reintegration of OFWs, managing remittances, and combatting human trafficking. Speaking to CSOs working with returning OFWs, there were serious concerns over the mental health of OFWs for those who returned home after experiencing abusive living and working conditions. The trauma of repatriated and returning OFWs affected their whole households, as families struggled to adjust, support, and understand what they had been through. For those who were repatriated due to working conditions and unpaid work, the termination of a contract was considered a failed migration project.

Conversely, at the Commission of Filipinos Overseas (CFO) where mandated pre-departure orientation seminars (PDOS) are held, along with counselling for every Filipino emigrant leaving for permanent or long-term immigration, usually to the US, Canada, Australia, and Europe, prospective immigrants were largely middle-class. Clients were described by staff as middle class and usually emigrating through family sponsorship,

marriage, or “skilled” contract work. The complaints they received were around lack of parking space and the need for the option of online PDOS. The CFO gets annual visits from the Canadian embassy as well as updates on Canadian policy and information from a social services partner in Vancouver. Despite being characterized as less vulnerable, Filipino emigrants were still mandated to do the PDOS and undergo counselling. Among stakeholders I spoke with, specifically researchers and CSOs, a key concern was still the well-being of youth, whether they were left behind by parents working abroad or preparing for emigration to join their families overseas. The integration and adaptation of children was highlighted as a key issue among Filipino families of all socioeconomic backgrounds.

3.5.4 Data Source 4 – Textual and material sources

In addition to conducting interviews and participant observations, I also conducted content analyses of textual and materials sources, including immigration news and policy documents related to the LCP (e.g., government press releases, conference proceedings, grassroots meetings, policy briefs), subsequent caregiver programs, and migrant health. I searched and scanned grey literature, such as news releases regarding the Canadian caregiver programs from Canadian and Filipino immigration regulatory offices (i.e. Citizenship and Immigration Canada, Philippine Overseas Employment Administration) since 2000 and subsequently subscribed for news alerts where possible for future announcements (e.g., Citizenship and Immigration Canada, migrant network newsletters). The grey literature and media were analyzed prior to and throughout my fieldwork in order to contextualize discussions with participants regarding the information they received about the program prior to emigrating. Press releases and other grey literature

(e.g., guidance materials, reports, advocacy campaigns) from grassroots migrant advocacy groups and health and social service organizations were also analyzed.

My involvement with these groups and participation in meetings, conferences, and forums across transnational sites also directed sampling of materials, generating a significant number and diversity of materials to collect and analyze, including marketing materials from Canadian and Filipino recruitment agencies, international discussion documents, policy briefs, and conference presentations. Another important data source included in content analysis was art created by migrant care workers, including their reflections shared through art therapy, theatre performances by grassroots advocacy groups, and illustrations by migrant care workers of their experiences in Canada shared at public art exhibits. Through these works, including both oral presentations of their work as well as their written descriptions of their art pieces, migrant care workers were incredibly vulnerable and brave in intimate portraits about not only their work, but how they felt about life in Canada and being away from their families. During these presentations and discussions, women spoke of different tensions they felt about how far they have come, their current working and living conditions, their sense of belonging in different communities, and their dreams for their futures. Participants and key informants spoke frequently about social media platforms, such as Facebook, which were also important sites of both informal (e.g., Facebook group chats sharing processing timelines for permanent residency applications) and formal information (e.g., invitation to theatre performance) exchange that women utilized as a primary means of communication with their families, social networks, and to seek information on support resources (e.g.,

settlement services). While I did not join particular Facebook groups, I scanned public posts directed at or relevant to migrant workers.

3.6 Data analysis

Thematic data analysis was conducted to identify themes relative to the key study aims that emerged both within and across the data sources. The organization of themes were determined using the defining characteristics of a “theme” as outlined by DeSantis (2000) in a qualitative literature review :

1. Unite a large body of data that may otherwise appear disparate and unrelated
2. Capture the essence of meaning or experience and
3. Direct behaviour across multiple situations (p.355).

Below I unpack in more depth the process I undertook to develop codes and identify themes, working within and guided by the theoretical frameworks of global care chain theory and postcolonial theory. I followed the thematic analysis process through stages described by Braun and Clarke (2006) and similarly described in the step-by-step approach for conducting trustworthy thematic analysis by Nowell et al. (2017):

1. Familiarizing yourself with your data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

3.6.1 Familiarizing myself with my data

To begin familiarizing myself with my interview data, I transcribed all verbal data (i.e., participant and key informant interviews) verbatim and this served as the first stage of analysis. All interviews were conducted in English, however, in a few instances during interviews, participants could only describe certain feelings or events using phrases in Tagalog. As common colloquial phrases, I understood the phrases, but at times struggled to capture its meaning in an appropriate English translation. Transcription also necessitated paying close attention to each conversation and cues between speakers. Following the initial transcription of each set of data, I checked the transcription against the audio recording and reviewed the transcription for accuracy. At this early stage, I also reviewed my participant observation notes to verify and help with recall of important moments or issues that arose during conversations. Participant observation notes taken after each interview also assisted me with noting important milestones and events that participants and key informants spoke of. Across interview data and notes, this sequential mapping allowed me to better understand the trajectory of the women as well as key events or policy developments. Working within the frameworks of global care chain theory and postcolonial theory, enabled me to explore the pathways of women across different care settings within Canada, other countries, and with their own families.

Throughout the initial transcription and review, I noted points in the discussion that seemed to be of particular importance to the participants. For example, when speaking about some topics, issues, or events, participants evoked emotion, such as excitement, sadness, or frustration. During some conversations, interviewees also indicated when they felt something they shared was secretive, particularly private, or should be confidential.

These sensitive topics areas were also noted as significant and holding important meaning to participants, potentially indicating emerging themes. At the same time, I reviewed other field notes and reflective notes to contextualize any other factors (e.g., location) or recent events that may have influenced participants or key informants. These notes before, during, and after transcription also served to inform subsequent interviews so that I could be aware of potentially triggering issues or topic areas. Keeping this in mind was of particular importance when discussing traumatic events as well as various medical issues, such as pregnancy, surgery, or mental health.

3.6.2 Generating initial codes

Building from notes taken throughout transcription as well as my observational notes, I began developing codes. Codes were used to label and identify certain features of the data and sections of the text that appeared important and meaningful (Braun & Clarke, 2006) to the women's experiences. Beginning with data from interviews with the women, the initial codes generated allowed me to index the data and return to the codes in order to map and sequentially order common milestones that the women described, including when they learned about the LCP, began the application process, awaited a decision, prepared to go to Canada, upon their initial arrival, throughout their time in the LCP, and following the completion of the program. As women who were in the LCP shared a range of experiences, our conversations did not always follow a chronological or linear order. Women shared what or who was important to them (e.g., family, children) and how this influenced a range of their decisions before, during, and after the LCP. Common characteristics of their experiences were also noted, such as their educational and professional backgrounds, similar health concerns, information-seeking strategies, and

common challenges. Given these subjective experiences, global care chain theory and postcolonial theory afforded an opportunity to explore how women perceived their dual roles, work demands, family responsibilities, and perceptions of health. Initial transcript notes and mapping allowed me to compare and contrast across the women's experiences, identifying distinguishing features as well as commonalities to develop initial codes. The initial codes generated were applied to sections of text to identify and more specifically group milestones, similarities, and differences.

3.6.3 Searching for themes

The initial coding served to organize broader segments of data into chronological stages as well as features of these processes, noting different contexts and circumstances. Codes were first applied directly to transcripts and then prominent initial data codes were organized on an Excel spreadsheet where segments of data were input. Following the initial organization of codes and data into Excel, each participant's coded transcript was reviewed again alongside the Excel spreadsheet in order to compare data across participants by initial codes. Taking into consideration the different contexts of the women (e.g., number of labour migrations, family structure, previous occupation) and the series of events they described, as well as the distinguishing features of certain events, I began to identify overarching themes and sub-themes. This also included mapping timelines and developing tables to compare and contrast different characteristics of the women and how they entered the LCP. Key informant data was also coded, providing more context and at times more details, drawing on their expertise and previous experiences, often with a broad range of clients or community members who were in the LCP. Specific recurring issues were coded and input on another spreadsheet further

broken down by potential themes (e.g., arrival, employers, support networks, injuries, mental health) and sub-themes (e.g., looking for shelter, children, marriage, supporting family, elder care, violent, aggressive, sadness, loneliness).

3.6.4 Reviewing themes

With possible themes and sub-themes set out in spreadsheets, I reviewed the themes across data from both women who were in the LCP as well as key informants. Some broader themes emerged across a majority of participants who spoke to similar experiences (e.g., issues with mental health). By reviewing themes, it also became clear that some issues were prominent for certain sets of participants. The defining common characteristic between these participants was considered a theme and the different experiences that were a consequence of a common characteristic were coded and became sub-themes (e.g., immigrating from a ‘third country’ and using a recruitment agent). There were also outlying themes that were central defining events (e.g., injury, release upon arrival) for a smaller number of participants. These events were coded as a broader theme because of the long-term effects on the lives of the women and their families.

3.6.5 Defining and naming themes

The resulting themes and sub-themes were reviewed for consistency with specific data excerpts highlighted to ensure the consistency of coding the essence of theme. Highlighting key excerpts at this stage of analysis facilitated extracting key quotes for final reporting while helping to maintain the focus of respective themes and sub-themes throughout analysis. Data from the women’s interviews were centralized throughout analysis, while key informant data contributed a range of stakeholder perspectives and organizational insights on programs, initiatives, and priorities related to migrant care

work both historically and recently. To provide context to the central themes identified through interview data, I also reviewed the literature, general field notes, and key documents (e.g., newspaper articles). This process of content analysis and validation assisted in delineating processes (e.g., fraudulent recruitment agents) as well as identifying different names or terms used in the literature or colloquially to describe certain concepts (e.g., ghost recruiters).

3.6.6 Producing the report

The most prevalent themes as well as those with the most significant short and long-term effects were included in reporting. In consultation with my advisory committee, we determined that some themes and sub-themes would be beyond the scope of the study's research questions. As the themes and sub-themes were determined, extracts of data were selected that most reflected the essence of each theme while demonstrating the complexity of the women's experiences. The selected quotes illustrated the significance of a phenomena and its influence on the women's lives both in the short-term and long-term, as they reflected on how these events shaped their experiences.

3.7 Ethical considerations

3.7.1 Insider-outsider positionality

As a second-generation Filipino-Canadian woman who may share the same ethnic characteristic markers of participants, I remained conscious of how my culturally situated standpoint could impact participants and how I could be perceived as an insider-outsider (Carling et al., 2014). I was aware of the different ways being perceived by the participants as an "insider" could influence my interactions as a researcher and it was

important for me to be continually self-reflexive (Nowicka & Ryan, 2015; Wray & Bartholomew, 2010) and avoid assumptions (Asselin, 2003). For example, women at the drop-in centre and key informants were often curious about my personal background (e.g., relationship status, religious beliefs) and I was careful to balance answering their questions truthfully while not providing extraneous information. I was also conscious of “starting from a position of uncertainty” (para. 33, Nowicka & Ryan, 2015) when I tried to reject dominant assumptions, recognize my own bias, and asked follow-up questions whenever possible.

Moving between Canada and the Philippines during my fieldwork, my insider and outsider positions were constantly shifting and being negotiated as participants and key informants understood different identity markers such as my nationality, language, age, gender, and educational background (Nowicka & Ryan, 2015). I occupied insider and outsider positions simultaneously as the layers of these identities and positions of privilege shifted frequently between locations, speaking with women in the LCP, as well as key informants in the GTA and Manila. One way I tried to practice self-reflexivity as well as navigate my shifting insider-outsider position was through checking in with my advisory committee throughout my fieldwork and sharing written field reflections.

During interactions across communities, beyond sharing brief biographical details, I also tried to establish trust and build rapport by spending time with different groups when appropriate and in non-intrusive ways, such as community meetings or workshops.

Spending time volunteering at the drop-in centre gave me the opportunity to build rapport with participants and establish trust because I was able to have conversations and informally share information about myself and the project. In turn, women at the drop-in

center were able to ask me both personal questions, such as where I was from, what my family's background was, as well as what I was studying. As I shared different things about myself, I also made personal choices about what to disclose (Carling et al., 2014) considering how I would be perceived. For the most part, I was much younger than most of the women I interviewed and who came to the drop-in centre, which I believed made me less threatening to most participants. As an insider who understands Tagalog, I could follow conversations between groups of women at the drop-in centre and during meetings in the Philippines. In conversation, however, my limited verbal language skills in Tagalog forced participants and key informants to take part in interviews in English, which may have been more challenging or perceived as more formal.

Outside of the context of the drop-in centre, the parameters of my role as a researcher were often less clear to people in the community and participants. As Jorgen Carling et al. (2014) describe the insider-outsider divide in migration research, the researcher can be seen as a potential source of assistance with the immigration process. Indeed, I tried to be as clear as possible when introducing the research, its objectives, and what participation would involve to manage expectations of assistance. However, throughout the course of interviews, as participants shared medical concerns they (or friends) had or were currently experiencing, I felt it was pertinent to share relevant information about where to seek care. Given their changing immigration status and eligibility for provincial health insurance, I felt it was incumbent of me to verify they would be eligible for appropriate services in healthcare settings that were accessible to them, given their location of work or residence in the GTA. Given their emergent conditions, it was a priority to ensure their

safety at specific points of care and quell fears of seeking health services, so that they could receive timely care and become connected to healthcare resources, as needed.

In speaking with key informants, however, many shared anecdotes of several clients and community members they each knew who suffered from or passed away due to cancer.

Given the history of Juana Tejada¹, I had heard of a few cases of caregivers with cancer prior to the study, however, key informants spoke frequently of numerous clients who struggled to access cancer care. While key informants were often familiar with specific points of care and strategies for accessing care for migrants with precarious status, they also asked if any of my research networks or resources could help their clients. As cancer treatment largely takes place in hospital settings throughout the GTA and requires intensive and consistent care, it was the most difficult treatment to secure. The experiences of cancer patients specifically was beyond the scope of my study, however, key informants shared their range of experiences helping clients and their families access cancer treatment and for some, secure permanent resident status for themselves and their families throughout treatment.

¹ Juana Tejada arrived in Canada in 2003 under the live-in caregiver program. After completing the program, Tejada's application was approved for permanent residency, however, her medical examination found that she had terminal cancer and she was refused permanent residency and told to leave Canada. Tejada inspired a grassroots campaign that ultimately led to the federal government reversing its decision and granting her permanent residency in 2006. The campaign also resulted in the Juana Tejada law that lifted the medical inadmissibility clause in the *Immigration and Refugee Protection Act* in relation to caregivers' application for permanent residency. After her battle, Tejada died of colorectal cancer on March 8, 2009.

3.8 Conclusion

This chapter outlined the research methodology and critical ethnographic methods I employed throughout my research with women who participated in the live-in caregiver program in the GTA. I began by outlining my critical ontological and epistemological position. I then discussed the theoretical frameworks of global care chain theory and postcolonial theory that I drew upon throughout the study. I presented the critical ethnographic methods I utilized across all data collection sites and activities, including interviews with migrant care workers and key informants in the GTA, interviews with key informants in the Philippines, observational field notes, and content analysis. I then described the process of thematic data analysis that I undertook in order to identify and report on prevalent themes across the data. Finally, I shared the ethical considerations of the study, specifically how I reflected on and managed my insider-outsider positionality.

Chapter 4

4 Pathways to Canada

4.1 Introduction

The immigration of migrant women to Canada as care workers is often conceived of as a process involving two geographical locales, a point of origin and a destination (Cristaldi & Darden, 2011). However, this was only the case for a minority of my participants (5/16), who came to Canada directly from the Philippines. For most of the women in my study (11/16) the Middle East and different parts of Asia, not Canada, was their first destination as migrant care workers. Their time abroad shaped the type of information they received about Canada, including how to access the labour market, what immigration regulations existed, and who could connect them to employers. Foreign media, including newspapers and radio advertisements, and expanding social networks through new friends and social media platforms were valuable sources of information that instilled women with aspirations of moving to Canada with its promise of permanent settlement with their families. They worked with recruitment agencies abroad who promised to help them to fulfill this dream, for fees that amounted to between six months and two years' salary. These operations were often overlooked and unregulated by host countries, along with their Canadian counterparts.

The recognition of skills, training, work experience, as well as financial and social capital accumulated while working overseas facilitates what Paul (2015) defines as stepwise migration. Characterized by “short-term, multi-year overseas contracts in a series of countries organized to a socially-and personally-constructed destination hierarchy” (p. 440), stepwise migration is a process and strategy to use overseas-acquired capital to

finance further international migration. This process describes the journey of 11 of the 16 participants who initially left the Philippines to perform care work abroad in a destination other than Canada. Working anywhere from one to thirteen years in another country, these women learned more about Canada while overseas and then used the financial and social capital they gained while working overseas to find a way to immigrate to Canada with the ultimate hope of finishing the live-in caregiver program (LCP) in order to get permanent residency and finally be reunited with their families.

In Anju Paul's (2017) study on stepwise migration among Filipina migrant caregivers in Toronto, she outlines how caregiver placement agencies have effectively managed access to the Canadian market because they have become the de facto approach in other global care labour markets. During her fieldwork in Toronto, Paul (2017) found that along with prioritizing applicants with care work experience from "stepping stone markets rather origin countries" some "agencies point to long visa-processing times for applicants in origin countries like the Philippines that deter them from accepting applications from these countries" (p. 228). In light of processing delays, work experience, training requirements, and state imposed hiring regulations from both sending and receiving countries, migrant care workers increasingly rely on non-state actors, such as recruitment and placement agencies, to help them determine their prospects of where and who they can work for. Recruitment agencies play a pivotal role in shaping options and influencing the decisions of migrant workers as one of the only accessible sources of information on migration policies, potential employers, and how to navigate complex application systems. Recognition of skills, training, education, and work experience is both formally

and informally shaped by non-state actors in the absence of government mediation in the process of placing migrant workers with employers.

Like most national governments, Canada does little to connect its employers with prospective migrant workers outside of Memorandums of Understanding (MOUs) or Bilateral Agreements (e.g. SAWP) for specific industries (Nakache, 2012). Canada also lacks any meaningful oversight of recruitment agencies (nationally and those overseas that partner with Canadian subsidiaries), which have become the de facto approach to accessing the Canadian labour market for prospective migrant workers around the world (Faraday, 2014). The lack of transparency and little-to-no enforcement of regulations to protect them from exploitative recruitment agencies, migrant workers face extreme vulnerability as they negotiate work placements in Canada. Given these significant logistical and socio-economic challenges, prospective migrant women often chose to migrate to more accessible global care labour markets, such as the United Arab Emirates as well as East and Southeast Asia, before they arrive in Canada (Dickinson, 2016; Paul, 2017; Peng 2017).

Non-state actors continue to facilitate a growing number of care worker migrations that are marked by regional cultural, social, political, and economic characteristics and attitudes towards both care and migration. These factors in the context of receiving countries are combined with state labour export policies of sending countries as well as the accessibility of labour brokers. In Ito Peng's (2017) report "Transnational migration of domestic and care workers in Asia Pacific" for the International Labour Organization (ILO), she used POEA data to highlight that in 2014 there was a total of 1.43 million land-based overseas foreign workers (OFWs), of which "one fifth (21.3% or 304 623)

were deployed in just three East and Southeast Asian countries of Singapore, Hong Kong, and Taiwan, and the vast majority of them were women and in domestic services and caregiving” (p. 1). Peng (2017) attributes this to the liberal use of foreign migrant domestics and care workers in Singapore, Hong Kong, and Taiwan, where there is financial support, tax incentives and immigration policy reforms for hiring foreign domestic and care workers.

The immense influence of the culture of re-migration to Canada was described as pervasive in Hong Kong by six participants as well as several key informants. Participants cited needed work experience, reduced training requirements, faster processing times, and cheaper placement fees as their primary reasons for not applying to go to Canada directly from the Philippines as well as deciding to go to Hong Kong. As a more accessible market spatially, financially, and temporally, Hong Kong attracts the most newly-hired Filipino migrant domestic workers in the region (Paul, 2015). In Faraday’s (2014) study about temporary foreign workers and Canadian recruitment agencies, she found that migrant care workers were being charged the equivalent of eight to twelve months’ salary in Hong Kong before the cost of flights and transportation to work in Ontario.

In this chapter I outline the different ways the migrant women workers learned of the LCP, the different considerations they made when deciding how to apply to the LCP, and who facilitated their journeys. I detail the divergent processes undertaken by those who came to Canada directly from the Philippines in contrast to the participants who came from a third country. I first describe the experiences of the women who alternatively met these requirements through acquiring overseas care work experience in another foreign

labour market. I share some of their motivations for pursuing this route, including the increased accessibility and financial feasibility of entering other care labour markets first. I then discuss how the range of their mobility was influenced by recruitment agencies that determined which care labour markets they could access based on their care work experience and the immigration regulations set by nation states. Finally, I examine the challenges participants faced navigating the bureaucratic complexities of migration management of the Philippines government, including how they met training and certification requirements set out by both the Philippines and Canada.

4.2 'Imagined' routes to Canada

For eleven of the women I spoke to, it was while they were working abroad that they learned about the LCP, as they became particularly interested in the program because of the prospect of permanent settlement. For women with children, this aspect of the program was especially alluring because of the possibility of eventually sponsoring their children and being reunited with their family. The Canadian imaginary of citizenship and belonging (Coloma, 2018) for their whole family gave them hope that no other care market in the world offered. In this section I share the types of care work experience participants gained while working abroad, including those who worked as foreign domestic workers and those who were internationally trained health professionals. I also contrast what inspired them to go to Canada and how these motivations were distinct from their counterparts who entered the LCP directly from the Philippines. I then outline how and why most participants decided they needed to use a recruitment agency to go to Canada, consequently taking part in “third-country” recruitment whereby an OFW is recruited by an overseas agency to work in a second overseas country. Although most

participants went to Canada without returning to the Philippines, the Philippines government considers third country migration illegal because recruitment agencies overseas cannot be regulated or verified by the government (Battistella & Asis, 2011).

As characterized by Paul (2015), the first destination of migrant care workers creates “path dependency” (p. 440) because it strongly determines the range of options available for subsequent migrations. Also described as “dynamic” by Paul (2015, p. 440), the context of initial care work migration influences the ease at which migrant care workers can access labour brokers, the currency of their salary, and how their care work experience and training is recognized. In many “stepping stone” markets (Oishi, 2005; Parrenas, 2008), such as Hong Kong and Taiwan, access to information about immigrating to Canada is widely available.

Usually after years of working as a domestic worker or health professional in another country, the women who participated in this study were able to accumulate savings and build social networks abroad who talked about other friends who managed to make it to Canada through the LCP. More women (n=6) arrived in Canada after working for at least one year in Hong Kong, while others (n=5) arrived from other parts of the world, including Cyprus, Taiwan, Italy, England, and the United Arab Emirates. Only one participant had the initial intention of getting care work experience in Hong Kong in order to ultimately go to Canada. At the international level, the Middle East still attracts 60% of all Filipino migrant domestic workers, while only 5% travel directly to the West (Paul, 2015). Going to Canada from a third country meant not returning to the Philippines and OFWs bypassed repeating the Philippines deployment procedures, paying exit fees again, and relying on the Philippines embassy to process their visa. Paul (2015)

found that in 2008, there were 10 120 approved LCP applications from Filipino citizens. In contrast, POEA official data documented only 1853 Filipino caregivers deployed to Canada directly from the Philippines (Paul, 2015). This shortfall of over 8000 approved applications to Canada from Filipino citizens demonstrates the frequency of migration from a third country and likely indicates the power of non-state actors.

4.2.1 Getting care work experience

4.2.1.1 International foreign domestic worker experience

To qualify for the LCP, nine participants used previous foreign domestic worker (FDW) experience in other international care work markets, including Hong Kong, Taiwan, Cyprus, and Italy, to meet Canadian requirements. For six participants, Hong Kong was the most accessible stepping-stone market to enter because no prior care work experience was needed. Jenny went to Hong Kong to gain work experience with the ultimate aim of one day going to Canada:

I am a domestic helper. That's the thing about here in Canada, you have to go to Hong Kong to have experience so that you are qualified to come here to work here. If you have any experience like one year or more than a year in Hong Kong, then you're qualified to come work here [in Canada]. That's why I took that.

The women had to consider their options for further work migrations within respective regions, including the Middle East, East Asia, Europe, or North America. They weighed their decisions on the balance of both work availability and migration requirements and costs. For women like Jenny, who were already working abroad, the FDW experience they were getting would qualify for the care work experience required by the Canadian

government for the LCP. The promise of permanent residency after completion of the LCP was especially enticing and stood in stark contrast to the increasingly precarious and restrictive nature of temporary migration schemes for migrant care workers.

The cost of entry into these different global care markets was one of the main determinants for selecting their first migration as a FDW. Unlike some of the women I spoke with who were able to migrate directly from the Philippines to Canada, most women depended on work abroad to earn more for their families in order to pay for the cost of living for their families back home, continue to pay off debts, and try to save. While their salaries as well as the currency they were paid abroad made it possible to send money back home, it was often still not enough to afford migrating to Canada. For some women, such as Nicole, they realized it would take years of their salaries in Hong Kong to save enough to go to Canada, but they felt the urgency to go to Canada so that they could sponsor their children before they were too old to be considered their dependents. Nicole recalled the different considerations she made:

By that time, European countries slowed down so the application did not go through, so my mom asked me if I wanted to go Hong Kong, so I said yeah...I have the money, I will apply to Canada because applying here really takes a lot of money and I'm working in Hong Kong, but I need to pay Canadian dollars.

The excessive working hours and sub-standard living conditions of care workers in Hong Kong were additional factors that compelled some women to look to other job markets. For Jenny, working in Hong Kong was seen as a necessary sacrifice to fulfill her goal of going to Canada:

I was like I don't want to work there anymore, the employer was so bad, she's crazy...but no, I'm already here, I just need to find another job because I'm already here in Hong Kong and that's my stepping stone to come here in Canada so that's my goal. That's why I sacrificed, I really pushed myself to go through Hong Kong to come to Canada.

Nicole also experienced abusive working conditions, including working excessive hours without her day off being respected by her employer. Her employer's restrictive measures effectively gave them full control of all of her time, making her feel as if she was their property. She recalled how her employer violated her days off by still making her work once she returned to their house.

In Hong Kong, you don't have freedom. I worked six days a week, we started working at 6 o'clock until midnight, your day off is just one day and sometimes you have a curfew, you leave 7 am and then you have to come back 7 pm. After that, when you come home, you need to clean everything, but that's your day off, so you're still working.

Melissa described feelings of indentured labour and explained how the cycle of debt kept her bound to her exploitative job. After selling her things in the Philippines and then borrowing money to first work as a FDW in Hong Kong, Melissa explained how she felt like her employer treated her like their property. Through a friend she met in Hong Kong who was now working in Canada, Melissa learned about the LCP. When Melissa's friend offered her help to connect her with a recruitment agent, Melissa saw it as a chance to get out of Hong Kong. Using all of her money to pay the recruitment agent, she still had to

borrow more money from her father to pay for the plane ticket. Only with the social support and network connections of a friend, as well as a loan from her father, was she able to escape.

If you're a nanny, you're a slave, they bought you. They bought me from the agency. If they did something to you, you report, or they'll fire you, but you don't want to be fired because you sold everything or you owe a lot of money and then you go back to your country...I spoke to my friends here in Canada who was in Hong Kong before, so she said if you want, I can take you to a place so you can apply, I said "Ok, get it, get it." So she went here in Canada, she process it, but we paid a lot of money to the agency. I asked my dad again to give me some money for my plane ticket because I don't have enough money to come here to Canada.

A trend observed among younger women considering taking part in subsequent labour migrations between their first destination directly to another country was the development of their personal hierarchical preference. As these women developed their social networks in their initial migration destination, they learned about other global care labour markets through both personal contacts and the media. Based on this information and what they heard of others' experiences who they thought were in similar positions as them, they began to strategize their own series of labour migrations in a process described as stepwise migration (Paul, 2015). Victoria explained how she saw this becoming increasingly common among younger women she worked with and how they developed this intentionality and stepwise strategy to go through Hong Kong to gain work experience in order to go to Canada from the time they leave the Philippines.

During her time as a counsellor for domestic workers in Hong Kong, Victoria noticed the development of this pattern. She described the intensification of this trend over time:

A lot of the younger batches have that intention of moving to Canada and we're seeing that they're in Hong Kong for the primary reason that they want to make it a stepping stone so that they can go to Canada and be a resident in Canada and have the opportunity to bring their families to Canada. We always tell them you need to understand how much it will cost for you to go to Canada from here, where you will get the money, have a very reliable recruiter to help you go through this process because Canada is very far, unlike Hong Kong, in a matter of one and a half hours, two hours, you're home [in the Philippines] already.

As a social service provider in the GTA, Erich also noted how stepwise migration having a particularly detrimental effect on younger women in the LCP.

[Release upon arrival] it happens a lot, but caregivers, especially those that go to Hong Kong that want to come here, they're having problems when they're young. I had one client who's 23 and she doesn't know anyone here and she couldn't cope.

4.2.1.2 Internationally trained health care professionals

Unlike participants who worked abroad as foreign domestic workers before going to Canada, Aura and Carmela worked overseas as health care providers and spoke highly of their previous labour migration experiences. They told fond stories of the friends they made, cherished colleagues they worked with, and the overall employment security they felt. When Aura considered her long-term prospects if she stayed in Dubai, she grew

concerned that her family would not be taken care of, if she was unable to work because of sickness or old age. She knew her income and her family's livelihood relied on her employment and she would never have permanent residency, social security, or employment insurance in Dubai or the Philippines. Educated and trained as a physiotherapist in the Philippines, Aura decided to go to Dubai to work as a physiotherapist in a hospital. After Aura's ex-husband left her with her son and daughter, she anticipated she would not be able to provide for her kids with only her income as a physiotherapist in the Philippines. Hoping she could support her family through remittances, Aura left her children with her parents. She explained the limitations of being a migrant worker in Dubai:

In Saudi, you're always a contract worker, you're not going to get residency there so my fear again is I'm not going to be a worker forever in Saudi right, my fear is if I'm not able to work anymore and go back, even if I have paid vacation, it's not going to be enough if I get sick or to bring my son to university so my fear of what's going to happen again in the future and then my friend who first came here, I told you when she started processing with another agency and she was in Montreal, that's when she told me you could avail for permanent residency, so I was thinking oh that's good, at least I have a fall back right.

Carmela faced similarly difficult circumstances in the Philippines after her ex-husband left her and their son. Working as a nurse Carmela thought the only way she could afford to pay for her son's future and their living expenses was to try working abroad. She managed to get a contract working as a nurse in England when she first left the Philippines and continued to work in England for four years. As much as she enjoyed her

time there, her main motivation for coming to Canada was to be able to settle permanently with her son. She described how much she enjoyed working as a nurse in England and how she weighed that against continuing to be separated from her son:

Working as a nurse really, so I was happy, seriously, I was happy because even if I don't study there because here they require me to get my course done to be in the hospital, but there they recognized my work and training...About four years and then when the contract is about to end, I said to myself, I can't go on like this without my son, I'm not really happy.

The primary motivation for both women to go to Canada was the chance for family reunification and long-term security, however, due to changes introduced to the LCP while they were in the program, their dependents no longer qualified for family sponsorship. Once they arrived in Canada, both experienced problems with their initial employers and struggled to find new employers. As they faced these obstacles that extended their time to completion of the program, new policies were introduced regarding the age of dependents. In 2014, a regulatory change was introduced that would lower the age of dependents from under 22 to 19 (Canadian Council of Refugees, 2013). By October 2017, the IRCC reverted back to the under 22 age limit, however those who submitted their PR application between August 1, 2014 and October 23, 2017 would still be subject to the under 19 age limit (CCR, 2017). For Aura who arrived in 2012 and submitted her application in 2016, she was forced to make the difficult choice of leaving her then 20 year-old son off the family application and only including her daughter. At the time of the interview, Carmela was still uncertain if she would eventually be able to complete the program in time to include her then 20 year-old son in her PR application.

Due to the combination of employer issues and the constant introduction of regulatory changes to the LCP, the women were forced to manage their precarious employment in the face of increasing restrictions as they attempted to navigate increasingly complex bureaucratic policies and procedures.

4.2.2 Agencies

4.2.2.1 Information channels

The social capital and personal networks women developed abroad strongly influenced their pursuit of subsequent care work migrations, however, the enticement of settlement for themselves and their families that Canada offered was unparalleled. Information from friends in Hong Kong who were preparing to go to Canada themselves, or knew someone who had already been, was how most women learned about applying to the LCP. I spoke with Victoria in Manila, where she returned to after working as a counsellor at a CSO (Civil Society Organization) in Hong Kong for eight years. She did individual consultations and group workshops with Filipina migrant care workers about financial management. From her perspective, these informal information channels were valued as more credible and accessible sources of information compared to in-person or online information from recruitment agencies, government offices, or non-governmental organizations.

From my observation and experiences, someone from the community has been there already, it's almost like 'Oh they're able to go to Hong Kong, oh they're able to go to Canada, so what kind of work did you do? Oh, I can do that too.' Would they know how to go about applying for Hong Kong or applying for Canada, that's how information is passed. This is how we trace a lot of different

regional groupings of family members from the same community or relatives from the same communities going to Hong Kong and finding employers in Hong Kong because someone started from their community, went to Hong Kong or experienced the process and her family immediately becomes the expert on how to go out and what to do, so a very credible source of information already for them.

She also described the more recent intensifying trend among younger Filipina FDWs who left the Philippines to work in Hong Kong as a stepping-stone market to gain care work experience with the long-term plan of ultimately settling in Canada. Working in Hong Kong served the dual purpose of gaining care work experience as well as earning enough to save for a subsequent migration. With Canada at the top of their personal hierarchies of next destinations for care work, Victoria considered how much of an influence targeted promotions to FDWs in Hong Kong had on putting aspirational plans into motion. While in Hong Kong, advertised vacancies and opportunities in Canada for FDWs made the care labour market seem more accessible and realizing their dreams possible:

I'll be running a workshop for them, they'll say 'My goal really is to move to Canada' and in the past, it's really something of a plan for them, maybe, I don't know for how long Canada has been the second destination to migrant workers in Hong Kong, but I think maybe because of all these promotions about vacancies being made available to move to Canada, that's really like 'Oh this is an option for me then I can go that route, save up'.

Second to personal connections and referrals, foreign media was another major source of information. The demand for migrant care labour in other countries was heavily targeted to FDWs and specific cultural groups, such as Filipinas and Indonesians. Media outlets, such as online advertisements, radio stations, newspapers, or storefront advertising, promoted information and financing options about how to pursue subsequent care work migrations. Victoria explained how this targeted advertising to FDWs was far more apparent and accessible in Hong Kong than in the Philippines, especially for some women who came from rural areas of the Philippines. Despite the illegality of recruitment fees, finding an employer in Canada necessitated the assistance of placement agencies that required payment before departure. Victoria described how there was no shortage of recruitment agencies or money lenders, who sometimes worked together in Hong Kong to loan women money in order to initiate the process:

There's very regular ads coming out in different locations, in different communities. They do that through different community newspapers, "Move to Canada, this is how much you need to pay" so several agencies are posting ads...in Hong Kong. They have a lot more access to information, internet, newspaper, they're very well-targeted to different marketers when they're outside of the Philippines. When they hear that someone they knew who was a former domestic worker in Hong Kong is able to move to Canada, then that's where they'll get the idea. In Hong Kong they can do that because they're there already, there's financing companies you can borrow money from so you can start the process and that's it.

4.2.2.2 Illegal recruitment fees and debt accumulation

Women who paid illegal recruitment fees to individual Canadian agents were often left with debt and without employers in Canada. The debt accrued to pay these illegal fees further entrenches their vulnerability once in Canada. The lax regulation of recruitment agencies in sending and receiving countries has facilitated the expansion of this very lucrative industry. As partnerships between agents overseas and in Canada are developed, the availability of labor brokers continues to permeate while the cost of placements rise. The cost of placements was the major prohibitive factor for women already working as FDWs. They explained having to pay their first placement fee when they left the Philippines for initial destinations, such as Hong Kong, Singapore, and Taiwan, and then saving up to a year's salary to finance the subsequent migration to Canada. As a financial counsellor working with FDWs in Hong Kong, Victoria described how quickly the cost and consequences of deciding to emigrate accumulated:

If they don't have the cash with them or they won't have enough money to support that decision to leave the country, then they will have to borrow it and there's so much pressure for them to start and finish that process by making sure they get to leave the country because that's the only way they can pay back the money... There will be so many people approaching them already 'ok I can do that for you, you just need to pay me this much and I'll cover everything for you' and that's the way it works with the community. It's just a lot of different groups wanting to make money out of this population who will want to leave the country or even if they are overseas before.

Ryan also discussed the burden of debt OFWs are willing to accumulate in order to pay recruitment fees with loans, despite the illegality of recruitment fees, which are supposed to be paid by employers. Participants were often asked by recruiters for payment up front or to send money in installments overseas so the money for placements would be made prior to arrival. Regardless of how women took out loans, the pressure of paying back debt significantly shaped their decisions about jobs, employers, and clients once in the destination country:

How much they would need to invest before they go, so anywhere from \$450 to \$2000. Most of them won't have that money, so most of them borrow from somewhere, so they've left with a debt. That fact that they you left with the debt means you don't want to come home unless you've paid that debt (Ryan).

At Leah's Toronto community organization, she met numerous women who were in financial precarity after paying a recruitment fee to get into the LCP. Leah outlined how the lack of recourse against recruitment fees has also allowed recruitment agencies to persist and continue to charge illegal fees. Many of her clients shared the perspective that they paid for a service and did not want to take action against the recruitment agency and preferred to continue to pay off their debt while working in the LCP. Despite the financial pressure they felt to stay with exploitative employers, they were not willing to take action against any recruiters from fear it would detract from their main goal of completing the LCP or even jeopardize their application. Fighting to recoup the cost of the illegal recruitment fees was seen as taking away from the little time they had to finish the LCP. She described how both financial and time pressures as well as fear of reporting to authorities were all part of the systemic perpetuation of illegal recruitment fees:

The biggest problem that I see is sure there might be a job at the end of recruitment process, but you're already in \$5000 of debt as soon as you arrive here and there's a problem with a lot of caregivers I've met, I'll ask them "Would you like to file to get those fees back?" And they say "No, no it's okay, I agreed to pay them" and often it could be a recruitment agency back in the home country working with a branch here, maybe the recruitment agency people are from their home town or know their family members or just generally, "I paid them and I got a job, I just want to get through this pathway with no issues, so it's okay."

Illegal recruitment fees were so common and frequent throughout the community, that paying to work in Canada was normalized among most of Leah's clients. Many women simply accepted the illegal fees as part of the price to come to Canada.

4.3 Philippines migration management

In this section I share the most challenging requirements and application processes highlighted by the five women I spoke with who emigrated directly from the Philippines to Canada. A theme across data from participant and key informant interviews was frustration with the requirements set by the Philippine government, which felt imposed on OFWs and were believed to be very costly and time consuming. The Philippines state maintains its position as a manager of migration that does not promote emigration, but rather facilitates the choice of its citizens to pursue working abroad. Central to its support of OFWs are a range of mandatory protective measures, including pre-departure training and bureaucratic exit procedures. The pre-deployment procedures are implemented to document where citizens are going as well as verify their documentation. Instead of providing security for OFWs upon their departure, many felt the arduous process

hindered their departure and at times even threatened to jeopardize their job offer. I begin with the caregiver training and skills (i.e., language proficiency test, first aid certification) required by the Canadian government to qualify for the LCP, followed by the extended processing times for applications (18 to 30 months), and then outline the pre-departure documentation mandated by the Philippines government. Together, the cost and time to satisfy these requirements of both the Canadian and Philippine governments were major barriers for the women I spoke to who were successful in the application process, as well as deterrents cited by others who decided to go overseas instead.

4.3.1 Training and skills acquisition

To qualify for a work permit under the LCP, applicants had to meet specific language, education, and training requirements set by the Canadian government, including but not limited to: fluency in one official language, completing the equivalent of a high school education in Canada, and full-time training for six months or one-year full time work experience as a caregiver. When making their decisions about completing the caregiver training or immediately going overseas to get care work experience, financial means was the primary determining factor for participants. Princess completed the mandatory caregiver training program in the Philippines, despite her nursing bachelors education and training. After recently graduating from her university nursing program, Princess was not able to find a job and instead volunteered as a nurse at a hospital to get work experience. As a single woman without children or other family members to support, she decided to try to go to Canada through the LCP. The first step for her was getting her family to financially support her to pay for the caregiver training program. Later on, her family would continue to help pay for her applications and processing fees. Without work or

savings, her family's financial support was the only way she could afford the training, processing fees, and flight to go to Canada:

They [our families] have to give us money to do this, there's no jobs back home!

It's really expensive. My agency charged in US dollars and at that time, the US was crazy, plus the airfare, 50 000 pesos, \$1000 USD something, it's really big money...

Princess was the only participant who managed to file her own application and process her documents without the assistance of a recruitment agency. After paying for the application fees, she waited two years for a response, which was a period of significant stress and uncertainty for the entire family. Despite not having to pay a recruitment agency, the time spent unemployed as she waited to hear back about her application contributed to significant financial hardship for her family.

The three other participants who completed the caregiver training course in the Philippines also received financial support from their families and spouses for tuition and to maintain their family's income. Pursuing immigration to Canada was a family choice that was often described as a long-term investment for the social and economic well-being of the family as a whole. It was also believed that a larger income through remittances with Canadian currency would, eventually, cover the cost of immigration as well as help pay for daily living needs in the Philippines. The first step to initiating the process of applying to go to Canada through the LCP was enrolling in the caregiver course.

Two other participants who were also nursing graduates and could not find jobs in the Philippines paid to volunteer as nurses to get hospital work experience. Without job prospects as nurses in the Philippines, two women I spoke with who were both single with no dependents had aunts in Canada who encouraged them to apply to work in Canada as a caregiver. Lisa shared the sentiment that for her, the caregiver course turned out to be more valuable and useful than her nursing degree. Despite the years of university education and training they had as nurses, they still had to go back for training specifically for caregivers as delivered by the Philippines Technical Education and Skills Development Authority (TESDA). Lisa remarked, “I graduated nursing and volunteered for a couple of months but then I did the caregiving course. I used my caregiver transcript, not my nursing.” Lisa explained that many of her fellow graduates found themselves unemployed, struggling to find jobs, unlike cohorts of nursing graduates decades before them who were able to find work overseas as nurses.

The cumulative time spent to undergo training (including course work and placements), and then wait for all of their documentation to be processed for visa issuance, all while not working, was a significant barrier some could not afford. The time and cost of training and other requirements made Canada an inaccessible care work market to enter for most, unless they had financial support. Lisa mapped out how much more difficult it was to go to Canada as a caregiver than most other global destinations for care work:

If you go to Hong Kong, you don't need the course. That's why Canada is so hard for Filipinos because you have to take 4 year course, 72 units, you cannot come to Canada if you don't have a degree and then you have to wait for 8 months or 6 months to come here, it ends up taking 1 year, 2 years to come here. Other

countries, if they have money, then they can come to Canada. In the Philippines, you have to sweat a lot.

Patricia explained in detail all of the steps she needed to take in order to satisfy the training requirements of the Philippines and Canada. The caregiver course consisted of in-class training followed by practicum training and upon completion a caregiver certificate would be awarded that would later be needed as proof of course completion for exit clearance. The caregiver course is overseen by TESDA at accredited private facilities to guarantee standardized quality training of OFWs (Rodriguez, 2010). Including several components to the caregiver course, such as CPR and first aid training has been argued as ensuring the added export value of Filipino OFWs to maintain global competitiveness as dependable skilled workers (Guevarra, 2009). Patricia spoke of how difficult it was for her to go through the arduous process:

After I got the certificate, I applied again for TESDA for another training, you need to pass the exam there. CPR, first aid, in order for you to get the certificate. It's very hard when you come from the Philippines to apply for a caregiver in Canada. If you went to Hong Kong, no you don't need it. Aside from that, after you pass the exam in TESDA, you need to pass another exam for the immigration, we call that the speech [TOEFL] test, it's like IELTS here.

Patricia also went on to describe how scared she was for the language test specifically. She recalled how daunting it was for her to do the examination, especially knowing how often people failed. She was proud to say that of the 17 people she took the test with, she was one of the three people to pass.

4.3.2 Processing times

Processing times for applications and visas were lengthy and all five participants who applied in the Philippines waited between 18 to 30 months. Processing applications in Hong Kong took far less time, often only a few months. The period between securing a job offer and being able to leave for Canada was a time of great uncertainty, anxiousness, and fear related to the loss of valuable job offers. Both their ongoing employment in the Philippines and job offers from Canadian employers hinged on processing times, as people grew increasingly anxious about jeopardizing their jobs. With processing times often taking longer than a year, people began to look at other potential labour migration destinations that would be closer and faster to get a visa for. Other participants, like Jessica, began looking for other jobs abroad and felt very disheartened about the prospect of making it to Canada:

Before I came here and I was processing my papers to go here, it was so much and I already lost hope like I don't want to come here anymore and applied for another teaching job in Thailand. I was hired and then my sister told me just wait. Actually I booked a ticket going to Thailand already. The one accompanying me to go to Thailand had problems travelling so she cancelled and I was like, maybe it's a premonition for me not to go. I never ended up going.

Lisa also thought it would never happen after waiting for nearly three years, until suddenly she received a notice that she would need to go for a medical exam:

I started processing December 2012 and I waited for almost two years, I came here June 2014. Processing in the Philippines is really hard, it will take long...In

those two years, I don't think I'll come because it's too long already, maybe it wasn't approved since I've been waiting for almost three years...I wasn't hoping anymore and then they emailed me for a medical for a visa and my passport and everything, I was so happy at the time.

Princess experienced frustration and worry throughout the whole process, which was exacerbated by the mounting pressure she was feeling from her aunt who was helping her from Canada. She recalled how doubtful she was about her application, going as far as keeping it a secret from her family: "They didn't know when I submitted my paper, I didn't tell them because I didn't think it was going to push through. When I first submitted all the documents, I had to wait how many months, a year." In spite of her aunt's suggestion to use a recruitment agency, Princess decided to try to file her own papers and manage her application. Princess feared that any problems with the application would be seen as her failure by the family because of her decision to apply by herself:

My aunt told me too, I think you need an agency, but wait from the embassy the next steps you're going to do. When I received the mail, they just said do this and this. It took me one and a half years to complete everything. Since I submitted, I received mail that they received my application, but nothing happened. My aunt keeps telling me what's happening? What's happening? Why is it taking so long? Because she did already her part, the LMIA, then it's me. The instructions will not allow you to go to the embassy, the guard will say sorry, you have to fax it. If I call the call centre, they say you have to wait for the next time.

The entire process of applying from the Philippines took Patricia two and a half years, and that was with a secured job offer. Patricia's sister in-law was already working for this employer when she shared they wanted to have another child, but would need another caregiver. Knowing Patricia's expertise in teaching children with special needs, her sister in-law thought of her immediately and connected her with her employer. Trusting both Patricia's sister in-law's referral and Patricia's particular teaching experience, this Canadian employer agreed to give her a job offer and wait for all of her papers to be processed. After Patricia received a job offer from a Canadian employer, it took her one year to complete the caregiver course and then another year and a half for her papers to be processed. Patricia remembered how long it took and how she thought she would lose the job because of how long everything took:

She was waiting for me for two and a half years because that time when my sister in-law told me that my employer is willing to sponsor me was the only time I decided to enroll in the caregiver course and then after that it took ten months and then another two months for training in the hospital and training for the elderly and home for aged...One month for the hospital, one month for the elderly and child care.

Patricia also began to doubt her employer would wait for her after so long. After setting in motion her application when her employer was first planning to have another baby, her employer got pregnant and gave birth in the time it took for her papers to be processed. She recalls, "My employer waited for me for two and a half years. I thought they were not going to wait for me... and then during that time they had another baby!"

4.3.3 Philippines pre-departure orientation session (PDOS) and post-arrival orientation seminar (PAOS)

4.3.3.1 Mandatory pre-departure orientation session (PDOS)

One of the key distinctions of Philippines migration management is the structured deployment system, including a mandatory six-hour pre-departure orientation session (PDOS). Delivered by state-accredited agencies, the objective of PDOS is to ‘empower’ OFWs for their time working overseas through education on topics, such as employment contracts, airport departure and arrival procedures, cultural expectations in the destination country, and challenges of families separated by migration (Gueverra, 2009). As one of the first countries to introduce a mandatory orientation session, the PDOS is a global example of how to train prospective OFWs for other major migrant worker sending countries, including Indonesia, Sri Lanka, Bangladesh, and the United Arab Emirates (UAE) (Spitzer et al., 2015). The PDOS is central to the Philippines migrant worker culture as the intervention reinforces nationalist values, such as one’s moral responsibility to behave appropriately and provide support for their family, even while overseas.

Rodriguez (2010) asserts that rather than providing real protections for workers, the PDOS is another arm of the Philippines state labour export apparatus in which workers are taught to self-regulate and are instilled with nationalist ideals of a gendered moral economy (Rodriguez, 2010). Rather than provide valuable information in a meaningful way, the PDOS has been criticized as another strategy to influence the behavior of OFWs and strengthen their sense of duty to the country and their families even while abroad.

Key informants expressed that health and mental well-being has become an increasingly important concern that needs to be addressed and added to PDOS curriculums.

Established in 2016, the Philippine Migrant Health Network has called attention to the need to enhance the health component of PDOS as one of its key priorities. Moving beyond safety hazards and public health threats, health officials recognized the need to provide OFWs with material information about how to manage their health once in the destination country, including how to access health care and health services as well as maintain a healthy lifestyle. As the number of OFW repatriation cases all over the world increased, the need to address health matters and specifically the mental health challenges of OFWs has become a pressing concern. A health official acknowledged the need to shift and expand how health and safety is currently framed within the PDOS:

What we're trying to address is really including the pre-departure orientation seminar and to basically include the health component, which has to be all the elements because most of the elements now are more on the infectious ones like HIV/AIDS, but because of all the medical repatriation cases, I think we need to involve mental health in the module like stress management, coping with distance.

Glen was a health provider who consulted on PDOS and he described the shift they were trying to make, "Looking at workers not just from an infectious angle, but more on the health promotion dimension." This included discussing ways to maintain healthy lifestyles, including healthy diets as well as primary care concerns, such as where to access health services.

Prospective migrant care workers were also required to undergo a Stress Management seminar as another component of their PDOS, however this session could only be

attended in the capital region of Manila. The women and key informants noted how the magnitude of information shared as well as the logistics of delivering the session, such as scheduling, location, and accessibility of information limited the effectiveness and value of information shared during the PDOS. One key informant who was a counsellor at a civil society organization described the struggle that some of her clients experienced:

I don't know what percentage they'll really retain in their heads because the session is happening one or two days before they fly out that they need to schedule that day because if they're coming from the provinces and PDOS can only be attended in Manila and the airport of origin to the destination country will be Manila, then they will make sure they do that and get the certificate before they fly out to cut down on expenses and imagine what other things are in their head outside 'I just need to spend a few hours just to attend this, get the certificate', maybe the first 30 minutes of a three hour session.

In addition to training certifications and PDOS, the Philippine government also requires OFWs to become members with Overseas Workers Welfare Administration (OWWA). This membership includes social benefits (e.g. disability and dismemberment, death), training, welfare (e.g. overseas counselling), and repatriation benefits. Medical coverage for both OFW members while abroad and their dependents in the Philippines is also available as an option to purchase, however both health and government officials noted the extremely low uptake of PhilHealth by OFWs. Aside from medical coverage through PhilHealth, documentation of fulfilling all training and paying membership fees are all required to get Overseas Exit Clearance (OEC). Participants recalled their experiences of getting exit clearance as Lisa could remember what she spent throughout the process:

2000 [pesos for PhilHealth] if you're an OFW. For the OWWA, OEC, and PhilHealth, less than 5000. OEC is Overseas Exit Certificate. OWWA is like if something bad happens to you, they will repatriate your body for free, they will give you some money from the government, like contribution. If something bad happens, they will give it back to your family

Mary expressed her frustration at the whole process describing it as, "Like cancer of the wallet. You're paying for the agency here and you're paying for your own airfare, it's like additional expenses the orientation." Princess also shared Mary's sentiments and went as far as calling the process exploitative:

The concept is the embassy here in the Philippines, the main problem is the Philippines. Everything is slow...They just have a paper and say you have to pay like this, ok, and there's another thing you have to pay, ok. I don't know how to sum it up. If you go there, you just have to go with a lot of money. Every window, you have to pay the fee for this one. It was like a hold up. They're billing you everything because they know with the currency, you're going to earn a lot.

4.3.3.2 Post-arrival orientation seminars (PAOS)

The Philippine government through its embassy and consular services also conducts post-arrival orientation seminars (PAOS). Based on key informant interviews, the PAOS was introduced in the summer of 2018 in Canada and specifically in the GTA, facilitated by the Philippines consulate in Toronto. Follow-up with recently arrived caregivers to invite them to PAOS was only possible for those who arrived from the Philippines because of their OWWA membership, which was required for their exit clearance. Through OWWA,

PAOS is offered exclusively to members who arrive in Canada for work. The seminars are intended to provide context specific information to Canada and the GTA at a time when information may be more relevant to Philippines overseas foreign workers (OFWs). Aurora was one Philippine government official based in Toronto and she explained who and how they were able to reach attendees for PAOS. She traced the process:

In Manila they attend the PDOS, since July [2018] we started the PAOS, but we're only able to process those who are documented so when they arrive here, we require them to attend a half day seminar with us to discuss about the government and service, to discuss about Canada and their rights, remittance, communities. For that, it's limited because we can only contact those who are processed through us. Those who came from other countries, we're not able to capture them, but how I wish we could invite them...When their documents are processed with their employer, the undertaking says there that the employer undertakes to send the worker/caregiver to attend the PAOS upon his or her arrival so we follow-up with the employer. As of now, we do it once a month...So far, the attendance has been like 70% of those that have arrived have attended the PAOS.

Aurora admitted that PAOS in the GTA was still in its developmental stages and had limitations, such as which Filipino caregivers they could capture. She also noted that the content was also still being revisited and health wasn't currently part of the session because it isn't usually the immediate priority of recently arrived caregivers. Aurora explained, "When it comes to health, it's not yet something we've incorporated into our PAOS and I'd like very much to add that. When they come here, health is never a

concern, only when something happens to them.” There were benefits, such as the PAOS, as well as added costs for those who came directly from the Philippines. While the balance of the costs may outweigh the benefits, accessibility to the Canadian labour market was largely determined by the financial ability of these participants and their families to afford the costs of training and application processing fees.

4.4 Discussion

Accessing the Canadian labour market directly from the Philippines required significant economic and social capital to undergo considerable training to meet both Canadian and Philippine requirements. Women who went to Canada directly from the Philippines often already working as professionals who viewed migration as a strategy for class mobility or to maintain their family’s lifestyle, and not a means of survival to support their dependents and families. These participants were often highly educated and their departure was supported by family or a friend both in the Philippines and Canada. Despite their degrees and professional background, the mandated caregiver course, work placements, language testing, and overseas exit clearance requirements (OWWA, PDOS) were viewed largely as impediments to their departure rather than educational and empowering learning experiences. Visa processing times were also a significant deterrent for those who were not working or who didn’t have other means of support in the time between submitting an application and departure, leading them to instead first work in another overseas care labour market instead.

To bypass and expedite the process of acquiring work experience and skills training to meet the rigorous criteria of both the Philippines and Canada, care work migrations in intermediate destinations were common among participants. The response of Philippine

recruitment agencies to increasing restrictions introduced by Canadian immigration, along with the accessibility of other foreign care labour markets, was to stop or significantly limit placements to Canada for the LCP. This restriction in placements intensified the trend of getting care work experience in an initial stepping stone destination and delaying entering Canada through a third country until enough foreign capital was accumulated to finance a subsequent migration. The treatment, working conditions, and restrictive options for permanent settlement they encountered in other global care markets further contributed to the attractiveness of the Canadian LCP. The accessibility of other global care markets both pulls migrant care workers to leave their home countries, but working conditions and no possibility to settle or be joined by family pushes migrant care workers to seek subsequent care work destinations. In this way, immigration regulations of receiving countries plays a strong role in influencing both the mobility and immobility of migrant care workers. The desire for family reunification and to escape exploitative working conditions uniquely shapes the vulnerability of FDWs and their willingness to assume increased risk and debt as a means to pursue consequent care work migration.

While governments are a powerful force that establish immigration and labour migration policies, non-state actors effectively regulate both recognition of skills and accordingly the range of destination options made available to migrant care workers on the ground. Partner agencies across sending, receiving, and stepping stone markets make up recruitment chains that effectively act as gatekeepers at each point. As the recruitment chain lengthens between partnered labor brokers operating in different countries, the difficulty of tracing accountability increases (Faraday, 2014). Despite attempts by

sending countries, such as the Philippines, that aim to regulate recruitment agencies operating within their jurisdiction, their efforts are thwarted by overseas partners operating in destination countries that fail to enforce compliance measures for ethical labour recruitment. Recent changes to Philippine recruitment policies that prohibit direct hiring of care workers further necessitates the use of recruitment agencies to facilitate job offers.

While sending countries and migrant families bear the burden of separation, receiving countries reap the benefit of migrant labour with little consideration of the consequences for their failure to effectively regulate recruitment agencies and the inordinate risk migrant care workers assume. Destination countries have the international responsibility of implementing a comprehensive approach to regulating ethical recruitment standards as they benefit the most from the labour, precarity, and risk that migrant care workers take on. The primary reason for using a recruitment agency among participants was to find an employer and secure a job offer, however simplifying procedures and increasing transparency around processing times could make the application process significantly more accessible for independent applicants. In the next chapter I discuss the experiences of participants upon landing in Canada and how their relationships with recruitment agencies and employers shaped their time throughout the LCP.

Chapter 5

5 The influence of LCP structural features on occupational health and safety hazards

5.1 Introduction

This chapter explores the relationship between key features of the LCP and the women's decision-making during their migration journeys, specifically with regard to the many complex health and safety risks they navigated. While previous studies examine occupational health and safety factors that contribute to the vulnerability of Temporary Foreign Workers (Edmunds, et al., 2011; Salami et al., 2015; Hennebry et al., 2015) in agricultural and farming sectors, my data about precarity and health risks among migrant care workers in homecare settings is a unique contribution to the field because it adds new data on how conditions of isolation are produced exacerbated by precarious immigration status and employer-tied work permits.

Temporary foreign workers (TFWs) providing care in the home face higher risks of workplace violence than care workers in institutions or groups of migrant workers in agricultural or service sectors. Sargeant and Tucker's (2009) framework assess vulnerability of migrant workers in occupational health and safety, outlining "layers of vulnerability" that are used to describe the heterogeneity of vulnerability among different groups of migrant workers. Within my study, vulnerability of women's occupational health and safety differed depending on factors like the receiving countries, types of work, and countries of origin. Additional issues like migration status (e.g., conditions of recruitment), characteristics of migrants (e.g., family, language, education, skills), and receiving country conditions (e.g., undermining of occupational health and safety and

employment standards) may also compound and entrench their precarity. These elements were factored into the decision-making process among the women as they determined whether or not to participate in the LCP. Among the key factors considered were the kinds of clients they could work for and the types of support they could access if they felt their safety was being compromised.

Without any supervisor to report to besides their employer, they had few formal sources of support as they made these difficult decisions about work, safety, and survival. This was a common experience, despite OSACH (2003) recommendation that agencies provide necessary counselling or other help to home care workers, who are permitted to refuse unsafe work when they have reason to believe that workplace violence will endanger them (Ontario, 2019). Due to the limited labour mobility of women in the LCP, refusing work by leaving their client was a drastic measure that women took only if they felt their life was threatened by staying in their client's home.

In this chapter, I examine in depth the complex ebb and flow of decision-making among my participants and highlight how employer specific work permits for the LCP create conditions of precarity that endanger the safety, legal status, and financial security of migrant care workers. However, I begin with a discussion of the women's family background and previous work experience. I then outline how the lack of regulations within the LCP and migrant home care work regulations often gave rise to dangerous/unsafe working conditions, particularly in instances of aggressive clients with advanced dementia or Alzheimer's. Lastly, I discuss the factors that shaped women's decisions to accept employment for elder clients or children and the distinct challenges the women faced working to provide these different types of care.

5.2 Characteristics of migrant workers

Characteristics of migrant workers was one element of Sargeant and Tucker's (2009) layers of vulnerability framework that influenced the levels of health and safety risks my participants were willing to tolerate. Family background was flagged by my participants as the most important factor that shaped their decisions, personal identities, and goals. Their family composition, number of children and/or family members they were supporting, as well as the economic and informal supports (e.g. child care) they could depend on in the Philippines strongly influenced the types of working conditions they would tolerate. Other characteristics included language, education, and skills, although most of my study participants had built these skills through previous care work experience.

After a work-related disagreement with her employer, Marlyn was forced to leave her employer in Saskatchewan and then decided to go to Toronto because she believed she had better chances of finding a new job. After finding a potential employer interested in hiring her, Marlyn had to wait to process a new Labour Market Impact Assessment (LMIA) in order for her work to count towards the number of hours needed to complete the LCP. During the time she had to wait for the new LMIA to be filed by her prospective employer, and then be approved by the government, Marlyn could not legally work. The extended processing times for the LMIA forced Marlyn to live without income at a time when she also did not have an employer to live with. Relying on shelters and distant family friends, Marlyn struggled to find housing during this time. Without any family and missing her daughter deeply, Marlyn described feeling hopeless as she struggled to survive. Despite this, she spoke of her steadfast commitment to abiding by the rules of

the LCP and not disqualify herself, so that one day she could sponsor her daughter. She described how tempted she was to accept temporary jobs for cash and “work under the table” like others she knew who were also struggling to survive as they awaited permits. Marlyn shared how much her daughter motivated her decision to continue trying to complete the LCP:

It's too long the processing [of the LMIA]. If only I had no daughter, I would hide and work under the table, but I have a daughter and that's her future. I think like that and sometimes I just feel really sad...I'm thinking I have nowhere, no family because the thing is, it's [the wait for the LMIA] destroying every plan because first, my health card, SIN card, my family, and of course the employer hiring me, they pay again.

While Marlyn's daughter was her primary motivation to follow the rules of the LCP, she also remained very aware that her immigration status, and consequently her eligibility for health care coverage depended on her work permit. She also noted how difficult it was to find any employer willing to pay for the LMIA processing fee that was previously prohibitive at a cost of \$1000. The issue of LMIA processing fees and times were highlighted by every woman I spoke with who had to change employers at some point throughout the LCP.

Issues with the LMIA were widely discussed throughout communities of care workers as many women described how they would rather stay with an employer who treated them poorly, rather than risk having to wait for a new LMIA. On the other hand, key informants working in the settlement sector notes that for many families with a need for

in-home care, the lengthy and expensive process of securing a positive LMIA also discouraged them from sponsoring a TFW already within Canada. Faraday (2016) outlines how the LMIA can be restrictive of the flexibility for both employers and TFWs in practice:

“Because the LMIA application fee has increased to \$1000, employers are more reluctant to make application. This results in it being more difficult for migrant workers who are presently in Can to obtain a work permit when they wish to change employers due to abusive treatment. While it is technically possible for a worker to change jobs, the process of finding an employer who is willing to make a LMIA application, complete the required advertising period, obtain LMIA approval, and then apply for a new work permit can take 5 or 6 months.” (p. 48).

Many women I spoke with not only had their own survival to consider, they also faced competing pressures to support their families in the Philippines as well as manage their recruitment fee debt. Finding any work that was available was an urgent need because the livelihood of my participants and that of their children and families’ depended on their remittances and they also needed to pay off the loan they took out to pay recruiters to go to Canada. Mary explained how many women could not afford to wait months for a new work permit, even at the risk of violating the conditions on their original work permits:

Some owe money in the Philippines. They can’t just sit down and wait for the work permit to come out, so they just have to work, they have to work under the table because the money they’re borrowing, it’s a big money. They’re borrowing

money, it's hard for the caregiver because first, they owe money and if you have a family, you have to send money back home, there's many factors.

5.3 Receiving country conditions

Receiving country conditions also shaped the women's precarity and led to numerous short-and long-term health outcomes, many of which were related to the lack of regulation related to recruitment agents and their working conditions. Here, I outline the health-related consequences of the fraudulent recruitment process known as "release upon arrival", which impacted three women I spoke with. I then discuss the ways in which the women's safety was put at risk as they faced homelessness upon arriving in Canada as well as the consequences of release upon arrival on their migration status.

5.3.1 Release upon arrival

All but one of my participants paid for the assistance of a recruitment agency given the difficulties of finding a Canadian employer as well as the complexity of the application process. While overseas (e.g., Hong Kong, Dubai, Cyprus, Taiwan, England, Italy), most of the women were referred to recruitment agents through word of mouth and connected with recruitment agents, rather than recruitment agencies. Through these private contacts with recruitment agents, the women made periodic payments through bank transfer throughout stages of the application process. Recruitment agents acted as private entities without Canadian authorization of an agency or organization, however, the women were not aware of how Canadian recruitment agencies and consultants were governed or regulated by the Immigration Consultants of Canada Regulatory Council (ICCRC). Indeed, upon arriving in Canada, the women discovered recruitment agents faced no

recourse for fraudulent placements or unsafe working conditions and few people ever filed complaints against them.

Of the 11 women who sought the assistance of a recruiter or recruitment agency, three were “released upon arrival”, which refers to the fabrication of employment by the recruiter; essentially they are abandoned with no legal recourse to recoup their money or solidify their employment in Canada. Release upon arrival was a particularly damaging situation because the women were also tied to their prospective employer for housing. From the moment these women landed in a Canadian airport, they were dependent on a recruiter to first pick them up at the airport and then ensure the fulfillment of their employment with the employer stated on their work permit. However, for the three participants who experienced release upon arrival, they were either not picked up by the recruiter or abandoned by them the same day they arrived.

I begin with Carmela’s story to trace how ‘release upon arrival’ had a detrimental impact on the health and safety of women in the LCP. After working in England as a nurse for four years, Carmela decided that Canada would be her best chance at sponsoring her teenage son. Carmela was put in touch with a recruitment agent by a friend. She described how little her agent did outside of processing the LMIA:

She told me to get in touch with the agent and she’s going to ask you for money, but it’s not that much. She helped me with the LMIA but everything else I did myself, like get the visa and I applied. Basically, she sent me an e-mail of the LMO (Labour Market Opinion), I sent back everything to the embassy to get my

visa signed, so it's not really her 100%, it's more me who processed it. She just got me an employer, that's it...\$5000 Canadian or about \$4000 UK or something.

After Carmela's recruiter picked her up from the airport and locked her belongings in the garage, she was told that the employer "wasn't ready" to meet her yet. As it turns out, she never met the employer on her original work permit and was just abandoned:

So she dropped me off at *the mall and oh my god it was so stressful and it was so traumatic really. You're vulnerable, your mind is expecting you'll be working right away and then she just dropped me off and went away. I don't even know this place.

Deserted at the mall without a place to work or live the day she arrived in Canada, Carmela was distressed and reached out to another woman on Facebook who she met overseas who was also planning to go to Canada through the LCP. Luckily, the woman was living in the GTA and agreed to pick her up from the mall. Traumatized, afraid, and alone, Carmela's first month in Canada was filled with anxiety and feelings of depression as she struggled to look for a new employer. Unsure of where to go or who to contact to find an employer willing to sponsor her for the LCP, Carmela sought help in Toronto's Little Manila.

After briefly meeting the family of a prospective client, they abruptly left her alone with the client with dementia, who could be very aggressive, during what the family called a "test run." Carmela did not have any information about where or how to get help for her client or herself, and without a new work permit for this specific employer her physical safety and legal status were in jeopardy:

It was the worst experience in my life. He's got dementia and I know, I understand their situation, but they don't know what they're doing. He got a hammer and almost knocked me out in my bed... then the man came over to my back and kicked my legs...I have to hide myself. He will calm down in like an hour. I just run. That's all you can do really. In the care home, you just lock the door. If one becomes aggressive, lock the door. They won't know the code and there's a glass there, so you can see them if they're ok. But just get off from them, that's the advice. I lock the door.

Carmela described the physical violence she experienced, but also understood the potential danger her client posed to himself if left alone.

I cannot leave him on his own. He might throw himself out of the window from the 17th floor. The first night, after what happened because he nearly beat me with the hammer, I got the duvet and I went to the bathtub and I put it in the bathtub and I slept there...For two weeks, and then I decided because it's really becoming worse and worse and the whole entire house is a mess. I said I need to call the cops. He might knock his head and I don't have a permit with this or a working permit with them yet, so I said this is not worth it. I'm fighting to stay, but it's not worth it. The guy who brings the medicine, he said call this number if you really need me because that's who I can call because he saw what happened. Nobody knows this.

As a nurse in the Philippines and a long-term care home in England before coming to Canada, she was familiar with older adults, however, she explained how there were

protocols in place for situations of aggressive clients at long-term care homes she used to work at. Working in the private home alone with this individual was ultimately too violent for her to continue working for this client.

Melissa was a care worker in Hong Kong who used her savings and took out a loan to pay a recruitment agent \$5000 to apply to the LCP. Similar to Carmela, Melissa was also a mother to a young daughter who was being looked after by her parents in the Philippines. After missing much of her daughter's childhood, she yearned for the chance to be reunited with her and to build a life with her in Canada. However, her dreams were crushed upon landing in Toronto, when nobody came to pick her up from the airport. Stranded and confused with jet lag, she fell asleep at the airport until being confronted by security:

On the first night, I slept in the airport on the bench because nobody came to pick me up, so the security [laughs]...I had the jet lag and my luggage, so I'm sleeping and they woke me up and said you can't sleep here or they'll ask you to go back to your country and I said I'm not leaving. I'm so tired so I slept on the bench there in the airport until the security spotted me because he said, "If you don't leave here now, they'll find out you don't have a job" and it scared me because I sold everything and then I have to go back?

After taking a taxi from the airport and being dropped off in the city's west end, she sought help from Filipinos she met at a convenient store who pointed her to an apartment where she might be able to stay. Melissa recalled that she did not have money because she spent her savings to pay for the recruitment agent, and was also in debt because her

income in Hong Kong was not enough to pay for the recruitment fees. Relying on the word of strangers in the Filipino community, she was desperate to find a safe place to stay for the night. She soon learned that there were many women like her room sharing as they worked odd jobs as they also looked for employers:

I found the convenience store, a Filipino store and then the lady asked me “Are you going home? We’re closing” but I stayed there the whole day because it’s cold and then she said “I wondered why you’re here” and I said “I only have \$100, I spent all my money” because I’m only getting paid \$1000 and after paying all my debts I owe, I only have \$100 Canadian...She said “There’s a little house behind us and there’s an old lady, she has a lot of tenants, young girls like you new here, try” but I said “I don’t have money” and “Just try” she said. So that lady said there’s no spot available, it’s only one bedroom and three of them [laughing], she said ok “When we go to work, you can sleep on the bed.”

For those who were released upon arrival, homelessness was a common, devastating outcome of this unscrupulous practice. Carmela and Melissa both relied on the generosity and advice of people in the Filipino community they hardly knew for support of all kinds, including housing. Melissa went on to share that the longer she was in Canada, the more she learned about how common release upon arrival was. Melissa continued her story about her first days in Toronto and her struggle not just to find a job, but to first find a place to stay: “There’s no room, five girls living in there, they’re looking for a job too. That time, our time, they can come here no problem, but there’s no work. It’s release upon arrival, all of us are like that.”

Another key consequence of being released upon arrival was the extreme precarity that women faced in terms of housing and the need to secure employment. They had to first work without a permit in order to establish a relationship with a family who would want to see if they could provide the care their family member needed. They were more willing to do trials with clients and take clients with advanced illnesses. Without a permit or avenues for getting assistance, the women were also at risk of losing their status. Their extreme vulnerability also involved being forced to deal with aggressive clients who could become very agitated. Despite these threats to their safety, the women remained dependent on a single employer for job security, housing, maintaining their status, permanent residence, and the chance to bring their families to Canada.

After landing in Calgary, Ashley was also released upon arrival and forced to join her sister who was also working in the LCP in a city outside of Edmonton. She recalled, “My agent told me they [the employer] backed out so they said they have to find me another employer, but I cannot find [one].” Ashley struggled to find a new employer in the Edmonton area and went through repeated searches for a new employer until she found an employer who said they would initiate the process of starting a new permit for her. After working for this employer for five months, she discovered they lied about filing a LMIA and decided she needed to leave them. Ashley’s time to finish the LCP in four years was further limited. Given the limited prospects for new employers in the Edmonton area, Ashley explained why she was inclined to trust her employer and hesitant to leave them:

I stayed for five months and I thought they already processed the LMIA and it’s been already five months and I’m wondering why they didn’t process anything so

someone told me you have to tell them you want to find another employer, so when I talked to my employers, I told them “I’m very sorry, but I have to find a new employer because I cannot wait any longer because my time is already running out and I have to have a work permit.” They were asking me to just give them more time...It’s been a year and turning six months.

The lack of transparency, recourse mechanisms, and guidance for TFWs to check the status of a LMIA, their employer’s status, any history of wrongdoing, as well as the legitimacy of recruitment agencies limits the women’s ability to make informed choices about their employment. The lack of reporting and oversight also increases TFWs’ reliance on their employers and further entrenches their vulnerability to be taken advantage of. Faraday (2014) also documented this phenomenon in her study where she outlined the key steps or typical patterns of release upon arrival:

A caregiver will arrive in Canada and be picked up at the airport by a Canada-based recruiter. The recruiter will immediately tell the caregiver that the employer is no longer available or has gone away on vacation, or will hand caregiver a termination letter from an “employer” who the caregiver has never even met. The so-called “employer” may be either a fictitious person or a real person who never had any intention of hiring a caregiver but who receives money from recruiter to allow their name to be used (p. 39).

5.4 Types of care work

The women’s precarious status and limited avenues to seek new employers often led them to accept work that was well beyond the scope of their contracts, especially in terms

of providing care for elderly clients and children. The types of challenges or risks the women faced were often shaped or defined by who they were caring for as well as the family dynamics they had to manage. Women who had clients who were older adults faced the most difficulties due to the intensive care their clients required. When caring for children, women faced particular issues with navigating the additional expectations of parents with associated housework as well as the emotional labour demands of the young children they took care of so closely.

5.4.1 Caring for older adults with complex conditions

Providing care for older adults with advanced complex conditions often meant the women worked hours that far exceeded the time expectations agreed upon with their employers. In addition to managing the medical needs of their clients, participants often discussed how they relied on the families of their clients to negotiate working hours and conditions. The cooperation of these family members as their employers was crucial to ensure their rights and safety. Those in the LCP were aware that it was imperative to maintain employment with the employer stated on their work permit in order for their work hours to be counted towards completing the LCP and becoming eligible for permanent residence. Many women were more willing to accept clients with complex needs requiring constant monitoring in order to maintain employment or for the chance to start a new permit. Clients' advanced conditions often demanded that those caring for them work around the clock, as Ashley explained:

Very stressful because at night time, she can wake up and do anything or go out, so you really don't sleep that well because you should always be alert because anytime

she can go down and she might fall down from the stairs. It's different. It's like 24 hours. You're paid for 8 hours, but you're working for 24 hours.

In addition to constant monitoring, clients with advanced conditions also needed intensive care. As a nurse in the Philippines, Princess fortunately had a clinical background, however, she was keenly aware that she was managing the client's care with minimal medical supports. Her employer was her client's son who lived in his own home while he left her with his mother and another caregiver. She elaborated on how stressful it was to be solely responsible for her client's overall care, including managing her appointments:

I was with them one year and three months...I really had to bring her to the hospital four or five times. If it's more on the breathing, I have to bring her, but sometimes I just have to call *community care and they're going to send somebody. I call community doctors just for something, if it can be done just with medications, I just call to book an appointment with *community care for a doctor to visit because she has nurse that comes to visit once and a while, but if it's about the breathing, we can't do anything, we have to call 911.

Despite the pressures of providing sophisticated care in an isolated setting and being in charge of managing her client's care as well as training new co-workers, Princess admitted that her primary motivation to remain in the job was to finish the LCP.

First few months is really hard because I'm already working like a nurse. Caregiver supposedly is just to be there, bring some food, change a diaper maybe, it's ok, but dealing with assessing her status, that's way too much already, it's not me as a

caregiver, it's me already like a private nurse and they're paying me like one...Dealing with my employer for more support or help is the more stressful part for me than dealing with my client because it's just us and the caregivers...I have to deal with every changing caregiver, I have to train them again because my companions has to leave, they cannot keep up because it's too stressful for them. All I'm thinking is I'm dealing with a family member because I really have to finish my nine months with them for the papers. It's like pushing yourself to do something just to finish for the papers.

While working with another care worker to split shifts for clients requiring constant monitoring, which was not uncommon, meant managing relationships with co-workers and this could introduce another source of stress. Without any supervision and limited resources, the dynamic between care workers could become tenuous. Feeling a lack of support from their employers and often managing their own competing psychosocial stressors from caring for a client needing intensive care, Princess described how her co-worker would take her own frustrations out on her:

Dementia, Alzheimer's is way different. I'm learning too. My co-worker's a nurse too. She's a nurse for how many years in Saudi, so for her too it's really, really challenging and the feeling like she was trying to throw onto me what she feels, that's why we're having a little bit of a hiccup because if she's so stressed, she's throwing it onto me, everything. She says she feels degraded because her position in Saudi is already like a supervisor and it hurts a lot.

The cumulative stress of balancing her client's needs, her co-worker's frustration, and her employer's expectations manifested in physical and psychosocial health outcomes for Princess. While she tried her best to manage her stress when she began to experience heart palpitations as well as rapid weight loss she decided that it was too much for her to handle. After consulting a doctor and seeking the advice of her sister ,who was also a doctor in the Philippines, she made the difficult decision to leave for her own health.

I had to leave for medical reasons. I've been sick. I guess because of stress, while working with them I had to deal with my co-worker too and we had to deal with my employer too aside from dealing already with the challenging patient... Those things already is adding to my stress and during those nine months, three months before I leave, I'm already losing weight very fast. Sometimes I go dizzy and black sometimes so I really have to go to the doctor and they were already advising maybe too much stress right now...Physical symptoms like heart palpitations and I did lose a lot of weight, 16 pounds within two months is really bad so she's already suggesting "I think you have to leave" because it's already physical symptoms."

A different participant, Aura, also worked alongside another caregiver to manage their client's care around the clock. As a practicing physiotherapist in the Philippines and then in Dubai, Aura had a medical background, but still felt she could not provide adequate care for her client who had Alzheimer's. She and the other workers switched shifts until it was no longer sustainable given the client's progressive Alzheimer's:

The first employer was nice, it's just that because of her mom's situation, I told you there's two of us right, but because her mom's condition is getting worse and she's

been aggressive... To both of us and this is our first time to deal with Alzheimer's. It's difficult because I really don't have any idea about Alzheimer's, I know that it's progressive, but you know like the aggressiveness and all that, no... I had to change her because she's soaked with pee and poo, but you can't, it's hard. That's when the daughter decided to bring her to a home and of course we have to find another employer.

Even with an employer that is understanding and a client that is compliant, the likelihood of most patients' condition improving is unlikely. Most times, the clients have advanced illnesses that require monitoring twenty-four hours a day. Given that the prospect of working with these kinds of elderly clients on a long-term basis was rare, women were often forced to find another employer and faced the challenge of getting a new work permit. Nenita described how much a client's family could influence her working conditions, alongside the nature of her client's illness:

She's good, very good, but now she's getting sick, I hope and I pray she has many more years to live because she's so good and very good family. This is important for me, the relationship of the family, so important... I feel bad because since then [the client's move from her house to an apartment], it's very difficult for me, she wants to go to bed and then after a few minutes she wants to go to the bathroom and then back to bed and on and on, so I'm really not sleeping... Every night, I can't sleep. She was calling her mom at night too. They sent her to the hospital and then I had my day off and I thought she would be back, but she's not and then they gave me my two weeks' notice because the doctor said it's difficult to tell when she's going to come back. She likes me and she wants to go back home but

I said I can't do it anymore unless you get one for the day and one for the night, so now she's in the nursing home.

Participants with aggressive clients were not made aware of any procedures they could follow or resources they could access for support during emergency situations. The women I spoke with only left their clients when they felt an imminent threat to their safety, which included being threatened by them with a weapon (e.g., stick, hammer). Nenita's prospective new client who had advanced dementia became aggressive and threatened her with a stick. After five years working for a client with multiple sclerosis who then passed away, Nenita struggled to find another employer. Despite years of experience working as a caregiver in Canada, Nenita relied upon informal networks to find a new employer. The health and/or mental conditions of prospective clients was not always shared transparently or made clear by employers and the only way women understood their severity was when they were already working in their home. The transition period for elderly clients with dementia to adjust to having a care worker live in their home could become particularly challenging, resulting in violent confrontations during aggressive episodes. Nenita recalled what happened when she started working with a new client with dementia:

I said oh my God, I cannot work like this, she's yelling like "I don't want anybody here!" She has dementia and she doesn't want to take a shower and it's more than two months and the clothes, the robe...She got the stick and she's going to hit me. I went to my bedroom and I locked the door and she knocked on the door "Open the door! Open the door! This is my husband's bedroom!"...I can't sleep also because

maybe she's going to go to your room and bang down the door...When I was with the lady for five months, I think I lost ten pounds.

Nenita endured living alone with this client for months, until she began to notice the physical symptoms of her distress, including sleep deprivation. With limited ways to seek help or report incidents of aggression, women like Nenita had to remain in dangerous situations and were unable to reduce their clients' agitation because she had no additional supports or resources. In Nenita's experience looking for new employers, she observed often only employers with family members with significantly advanced conditions, particularly dementia, were still looking for full-time caregiving help. She spoke of bouncing between clients with and the cumulative psychological toll of working and living in a series of unsafe homes:

I'm not happy. Sometimes I cry and I think this is not the life that I wanted. I can work the whole day, but this kind is crazy. I can't sleep. All night "I need help!" and I said "I need help too!" She's not like the other one that's violent, she's just agitated all night because she wants to go out, but she never hurt me. The other one for five days, she was violent...Of course, it's very scary...I'm scared for myself, but I'm scared for her too...She scratched me here by hand. There's a little bit of blood but I washed it off.

After encountering violent situations with clients, many women described feeling traumatized and as though they were living in a state of constant anxiety related to the prospect of their client becoming agitated and/or aggressive again. There were lasting negative psychological and physical effects following traumatic encounters with

aggressive clients, including physical injuries, significant weight loss, living in a state of prolonged stress, and fear, all of which had detrimental effects on the women's health.

5.4.2 Additional expectations of child care work

Participants who cared for children while they were in the LCP faced a unique set of challenges, particularly with respect to managing the expectations of parents and navigating family dynamics. Those providing child care were often also tasked with household chores, such as cleaning and cooking, in addition to the one to two young children they were usually responsible for. This often resulted in extended work hours that were unpaid, despite the agreement set out in their employment contracts provided during the immigration application and sponsorship process. Employment contracts were not binding for employers without provincial regulation or enforcement and workers had limited recourse.

Patricia had previous work experience as a teacher for children with special needs in the Philippines and was hired by her employer because of this experience. Her employer was the mother of two boys, one of whom experienced developmental delays. At the outset of the sponsorship process in the Philippines, she was well aware of the demand that providing such care for a child with special needs would require and she was explicit about her expectations for managing child care, tutoring, and housework. She spoke of how she tried to set out these boundaries immediately and negotiate her time management as they discussed her employment:

That's our agreement, if there's tutoring, no cooking. If there's cooking, no tutoring. That's what we agreed, but after a year, everything changed. I have

cooking, tutoring, everything. Before they had a cleaning lady, after my one year, they fired the cleaning lady and I do everything.

A little over one year into her employment, Patricia had a disagreement with her employer who demanded her tax return. She asserted her right to keep her tax return, but her employer had an outburst after which Patricia decided to concede and give her employer her tax return. This participant feared reprisal or termination of her contract, despite her conviction that she was asserting her legal right. She recalled how her relationship with her employer never recovered and continued to be tenuous for the remainder of her employment with the family. Her dependency on her employer compromised her ability to assert what she knew was her legal right. Following this dispute over her tax return, it was clear to Patricia that even the act of attempting to assert one's right with their employer could cause retaliation by an employer in the way of increasing work demands. Other consequences of potential employer reprisals could also jeopardize completing the LCP and her family's future. Lastly, Patricia had to consider not only her own daughters, but the well-being of the children she cared for. Patricia elaborated on the bind she found herself in:

For me, it's better to give my [tax] refund to her in order to keep the relationship and then I'm scared also that she might fire me since I need to wait another year to finish my 24 months...in a way, it's only money. For me, I need to finish my 24 months with her, so as long as I finish my contract maybe that's the time I can leave her. But after I got my papers, I go. Although it's too bad for me because it's hard for me to leave because of these two kids. Oh my god they're so cute and

every now and then, I want to see them...It's difficult for me because it's like I'm now the mother for them...I didn't want to let the boys go, still I love them.

Mary also discussed the bond she developed with the children she cared for and how it influenced her decision-making in certain situations with her employers. She enjoyed two years working with her employer when she had a disagreement over her evening work hours. Importantly, at the time Mary contemplated leaving her employer, she had already applied for PR and completed enough hours to fulfill the LCP. Despite enjoying this moderate security as she awaited her application to be reviewed, the responsibility she felt to the child outweighed the frustration she was experiencing with his mother. Following a confrontation with her employer, Mary expressed how she had to take into serious consideration what her resignation would mean for the child she cared for:

I think that kid has a special place in my heart...I got so mad and I cried when I got home, I wrote a resignation letter and I brought it to work the next day but my friend's like "No, don't rush it" because it's not only me, I think it's not fair to the child as well. I know they're not my kids, but sometimes you just have to be considerate as well because I'm going to hurt his feelings, I'm going to crush him because I know the feeling. When I went home [to the Philippines] last April, he cried buckets and he was holding my legs and he keeps sending my messages and DM-ing [direct messaging] me in Instagram. I didn't come to work that Monday and he was looking forward to it, he thought I was going back to work and he was looking at the window and I never showed up. I was sick, just all kinds of homesickness.

5.5 Discussion

The occupational health and safety of migrant care workers in the LCP was heavily shaped by both the conditions of their migration to Canada as well as who they cared for while in the LCP. The conditions of recruitment into the LCP strongly dictated the precarity of their immigration status and employment alike. Those who used recruitment agencies following stepwise migration from another country were particularly vulnerable to release upon arrival, which left women homeless, unemployed, and at risk of falling out of status. The illegal recruitment fees levied by agents also created financial hardship, putting women in debt before they arrived in Canada, and thereby increased pressure on women to accept dangerous working conditions in order to maintain an income and housing. The employer-tied work permits in the LCP were also a barrier to leaving unsafe work conditions because of the extreme difficulty women experienced searching for a new employer with a positive LMIA. Those who cared for older adults with dementia or Alzheimer's dealt with the most aggressive clients due to their progressive conditions and the lack of supports or training available to them within the home care setting. Of the women I spoke with who cared for children, their work conditions and working hours were determined by their relationship with their employer, despite their employment contract and/or employment standards.

Improving migration security and implementing proactive protection of migrant workers through the registration of recruitment agencies and employers would strengthen the security of TFWs' safety while in Canada as well as limit/prevent rampant illegal recruitment fees currently charged to workers. Coordinated action between the federal and Ontario government to regulate recruitment is necessary to protect TFWs and their

families from undue financial hardship and further ensure the safe settlement of workers in Ontario. Without these protections in place, OHS and ES protections and regulatory effectiveness will continue to be undermined (Cedillo, Lippel & Nakache, 2019). While immigration authorities and provincial regulators still have no way of tracking the location of TFWs and fail to ensure their workplace protections, women in the LCP working in employer's homes are especially "invisible" and removed from oversight (Cedillo, Lippel & Nakache, 2019). For women in the LCP coming directly from the Philippines, OWWA is able to trace, follow-up with, and invite their members to orientation upon arrival in the GTA. Those who undergo stepwise migration are therefore not tracked and receive no training or information about their rights or where they can turn to for help if the encounter unsafe situations. Beginning in the summer of 2019, the federal government introduced an open-permit to allow migrant workers to leave an abusive workplace (Migrant Worker's Alliance for Change, 2019). However, TFWs still face restricted labour mobility with the open-permit because they must continue to still look for work an employer with a positive LMIA (Migrant Rights Network, 2019).

The chronic stress of living with and caring for aggressive clients often manifested in both physical and mental symptoms for women in the LCP. Concurrently, many women faced social isolation or negative social interactions with co-workers that further exacerbated their psychological well-being (Cedillo et al., 2019). Migrant care workers' safety could be benefited by increased transparency of employers and recruiters sharing information about their client's conditions, history, and triggers as well as providing training on skills and strategies to identify and de-escalate situations when clients are venting. Information on migrant worker groups, labour advocates, or community

organizations on the ground who are best positioned to help TFWs should also be proactively provided prior to arrival and/or upon arrival before employers and recruiters can intimidate workers (Faraday, 2016).

In response to their clients' responsive behaviours that constituted workplace violence, women had few or no way of seeking help because they were not provided any information of who to contact in case of an emergency. For home care workers employed by agencies in Ontario, procedures to get help in a violent situation is part of employers' workplace violence programs. Home care workers are usually advised to terminate the interaction with the client, leave if they are told to leave, leave immediately if a client threatens with a weapon, leave and go to a safe place, call their manager, and/or call the police (OSACH, 2003; Ontario, 2019). In emergency situations, police are most often called, however for women in the LCP who may be between work permits, these avenues of recourse were either not available (e.g. leave to go to a safe place, call office) or threatened their own precarious status (i.e., call police).

Chapter 6

6 Managing migrant health

6.1 Introduction

This chapter describes how access to health services was often determined by the women's eligibility and entitlement to provincial health care coverage, which in turn was dependent on their employment status in various ways. Prior to addressing specific experiences conveyed by participants in my study, I introduce the policy contexts relevant to situating these experiences. First, I attend to federal-provincial distribution of responsibilities and policy areas in health care. I discuss how eligibility for health care coverage could change throughout the program and as the women awaited a permanent residency decision. I then address the considerations and competing responsibilities between their Canadian employers and families back home that women attempted to manage when deciding if and when to seek care, often producing significant delays to care. I then turn to the injuries and emergent conditions that were prominent throughout my interviews, followed by the participants' articulations of the general mental health impacts of participating in the program and performing care work.

6.2 Health care coverage eligibility

6.2.1 Between employers and work permits

Employer-tied work permits had numerous consequences for participants, including compromising their eligibility for provincial health care coverage. The effects of their recruitment, work permit, and employment contract had immediate consequences for their access to health care coverage. Princess explains her friend's situation after being "released upon arrival":

I have a friend and she doesn't even have OHIP [Ontario Health Insurance Plan], she doesn't have any work permit since she came here. How can she apply for work permit? That's why I tell her, never be sick! It's already one year and five months, she cannot apply for work permit if she doesn't have an employer...number one requirement [for OHIP] is if you're on a work permit, give me an employer's letter!

Marlyn also explained how dependent her immigration status, work permit, and health care coverage are on having an employer. She describes the cascading implications of being without an employer, which all lead to a position of heightened precarity, particularly with respect to accessing health services. After first landing in the province of Saskatchewan and then moving to Ontario to find another employer, Marlyn asserts that the requirements for maintaining health care coverage are far stricter in Ontario. Regardless of province, Marlyn sees a clear distinction between the guaranteed right to health for citizens and her conditional access to health care as a TFW, which is dependent on securing work:

I have my card, but it's expired. I have to renew it. In order to renew, I need a SIN card, but how will I have a SIN card if I have no employer, so all in one because that's what they did, but in Saskatchewan, there are exceptions and they help you...Caregivers is not a citizen here, not a permanent resident, we're only temporary worker here, but we have the same sickness, but the thing is because we are temporary worker here, I think it says on the paper that we have the same rights because if not, why are we entitled to a health card?

Leah explains how frequently she works with women in the caregiver community who have had serious health conditions requiring substantial medical attention during their initial period of arrival and the devastating long-term effects the three-month wait had on their health as well as their already tenuous financial status:

Often what ends up happening is either a caregiver is in their first three months and during that she's not covered and her employer hasn't purchased health insurance for her and so that means she's in this gap period where...there's a few women we've worked with that had surgery in that time, major medical events and now they're in thousands of dollars of debt, so that's something we definitely see. If a caregiver loses their job and for a long time, they can't find a new one, then they fall out of status and then it's difficult to start the work permit and then they have no access to health care.

Erich, another community worker, describes the effect of the mandated three-month waiting period imposed on women who completed the caregiver program and after becoming a PR. After waiting anywhere from six months to more than ten years for a decision on their family's PR application, the long anticipated transition to PR can ironically jeopardize women's health as their health care coverage is delayed due to the waiting period. Erich describes the case of one client who was pregnant during this time:

Now it's even harder, it's even harder and harder for these women. I also see, for example, this woman, a caregiver, her OHIP is expiring January 18, she got pregnant so what they did, they induced her 8 days before because the due date is after the work permit and her OHIP expired right...She already completed it [the caregiver program]! She's just waiting for her PR application...she could renew

her work permit application, but the three months...she doesn't have money, so if she gave birth after the OHIP expired, they gave her a list of expenses and the amount of money she needs for the OB-Gyne \$3000 plus right? And she said "I don't have money"

6.2.2 Open work permits and "implied status"

In the time between finishing the caregiver program and being granted PR, women move from a closed, employer-tied work permit to receiving an open work permit after submitting their application to be considered for PR. This indeterminate transition time awaiting a PR decision can last anywhere from six months to more than ten years as their entire family's application is reviewed together. This time marks another period of uncertainty and anxiety for the women and their families, even after completing the requirements of the caregiver program. Despite having fulfilled the work, medical, residency, and skills requirements for PR, the time to process applications leaves women with "implied status" in which they are in limbo and remain TFWs with uncertain access to services.

Administrative delays were described as having indirect health impacts as they were compounded by confusion around complex health and immigration policies between different work permits, which their health care coverage is dependent on. Erich spoke of the frequency and magnitude of the problem of processing delays during a specific period of time, which created a significant barrier to care and exacerbated health conditions due to delays to care. Erich explains:

With those folks in 2014 with the previous government, the processing of open work permits was taking long, so while waiting for the open work permits, the

existing work permit expired and that work permit is co-terminous with the OHIP expiry and so a lot of them who got sick, they were having problems accessing services, so we need to write a letter to the ministry. I don't know if you know Joel Santos* he helped us come up with the template letter and every time we have a case like that we write the ministry and they have a special thing, but they will not post it right, but the thing is that all caregivers don't know that and it's not definite so they postpone their medical appointments so we feel at that time women were like having cancer and illnesses and sometimes they will even postpone their medical appointments until it worsens and it's critical because they're scared that that would impede their PR application.

The advocacy work of settlement workers, with the assistance of lawyers in the community, was successful in having some exceptions made. While the MOHLTC acknowledged the right to provincial health care for some cases, the lack of clarification they provided and the inconsistent application of exceptions made still resulted in widespread delays or denial of care throughout the community.

The confusion around OHIP eligibility according to closed work permits and open work permits between finishing the caregiver program and applying for PR with "implied status" was made worse by the differential treatment women experienced at application offices. During this time of implied status, women spoke of being denied OHIP despite being eligible for coverage. Even after acknowledging that they qualify for OHIP, clerks explained to them that waiting months until the next permit was processed would save the office from having to process their OHIP multiple times after each permit. While the women expected they would receive their open permit within months, there was no

guarantee or clarification of when it would be sent to them or how far along it was in processing. Without this certainty, clerks continued to withhold OHIP in anticipation of their open permit, often leaving them without coverage for months on end. Lita recounted her experience: “I wait until I receive my open permit because they will not renew my OHIP because it’s just five or six months, they said if we renew it, we will have to do it again when you receive your open permit so they will not accept it so for how many months I don’t have OHIP.”

Throughout the community, women remarked on the different ways in which they experienced discrimination, particularly when attempting to access services. Due to the confusion regarding entitlement during the period of implied status, Mary spoke of how you would have to assert your case and if possible, bring an advocate who understands the policy. Mary said this was especially important when presenting at application offices for OHIP because of the skeptical and inequitable treatment women often experienced due to a combination of their TFW immigration status as well as racial discrimination. After almost a decade of living and working in Ontario alongside numerous women in the caregiver program, Mary is still unsure of entitlement to OHIP during implied status, but is certain of the influence that racial discrimination plays when applying. Mary said: “There’s some cases though, they have an employer but their permit is expired, but that’s implied status, right? I know it’s a different case...it matters also whoever’s the manager in a certain OHIP, you should really bring a person who knows what she’s doing...whether we like it or not, they’re going to base their decision on your colour. I’ve heard that many times.”

Women who finished the caregiver program, but never accessed or connected with community, settlement, or social support services, were sometimes not aware that they qualified for OHIP even with an open work permit. There was a lack of awareness of entitlement to services among women who completed the program during implied status. Where they could get clarification or take recourse was also unclear. As some women were awaiting a decision on their PR application for years, constantly renewing their open work permit was also challenging because of the hassle of also needing to renew their OHIP and the uncertainty of how their application for OHIP would be received each time they applied. Melissa was waiting for her PR decision for eight years and spoke of her frustration:

When my open permit expired [I didn't have OHIP], but I've been having open permit since forever, since 2009, so I'm paying my taxes, I'm working, it's not my fault they didn't give me my permanent residence status right away. That's why I want to complain, but I don't know who to complain to and for me it's not fair that I've been working so hard and then they're basing it on my status here. I don't know why they don't give us the OHIP based on the open permit, but we're legal working here.

Regardless of the women's eligibility for OHIP with an open work permit during implied status, many were denied health care coverage. After being wrongfully informed they could not have OHIP, many women would go years without health care coverage. Administrative delays for processing not only their PR decision, but also their initial open work permit resulted in the expiration of their OHIP. During implied status, women would go years without health care coverage for reasons from being unaware of their

eligibility to not appealing refusal of OHIP at another office. Once their OHIP expired with the closed work permit or open work permit, they would also face a three-month waiting period even after their renewal application was approved. After years of being uninsured, Jessica described how she was informed she would still face a three-month wait period even after successfully submitting her OHIP application: “Actually since November 2015, that’s the time my OHIP expired so until now [September 2016], I don’t have my OHIP. I applied for my OHIP last week and then according to them, my OHIP will be effective September 29 because my open permit was issued June so there’s a three-month waiting period.”

6.2.3 Provincial health insurance employment requirements

After completing the caregiver program, women still had to meet specific requirements and provide documentation to support their OHIP application, including an employer’s letter stating they would be working full-time for six months. The stipulated contents of the employer’s letter were not clear to many of the women and they asserted that this information was not available at offices or online as part of the instructions, documentation checklist, or guidelines explaining how to apply for OHIP. After being uninsured for more than a year, Jessica spoke of the hassle of having to make multiple trips to different OHIP application offices because frontline staff first made a distinction between processing a renewal rather than an application after expiry. Only afterwards on her second trip, the employer’s letter requirements were clarified for her by a clerk at the second office, until finally her letter was accepted as proof of employment on her third visit to an office. Jessica noted how the lack of transparency regarding the government’s

requirements created significant frustration, but also permitted clerks to exercise undue subjectivity when reviewing applications. She discusses what the process was like:

No, my OHIP expired November 30 last year and I don't have coverage until now [September 2016] because I just have my open permit. I applied for OHIP in Brookside* mall, I was able to get one but it's not until September 29. At first, I have difficulty with that one because when I checked the website, I thought I could go to any application office* to apply for OHIP and then I went there, there's one there and they told me "No, you cannot renew your OHIP here because it's already expired, you need to go to a different location" but when I checked the website, it says it can be renewed here, so I have to go for another day to Lockhart office* to get my OHIP and I showed my requirements and they told me "Oh you need to have a letter of employer saying I'm working full-time with them." I didn't know there should be a formal letter from the employer, she said "Within the letter it should say you are working permanent, full-time, you will be working for at least six months" that should be stated in the letter. I even told her "Why is it not indicated in your website? You should have indicated that so I don't have to go back and forth" and she said "It's says in there" and I said "Where?" and they couldn't provide me so I have to return another day to ask for the letter of employer again with that format. Fortunately, my boss is decent enough to give me another letter, so I have to go back again another day and then finally they approved my letter and then I thought they were going to keep it for their records, they just looked at it and returned it to me. I said, you're so strict

with your letter, and then you don't even get it. It's a waste of time. If it's really the policy, then you should put that in your website.

Marlyn highlighted the difference she felt between applying for provincial health care in Saskatchewan, the province she initially arrived in, and Ontario. In contrast to the leniency of being issued a health card after expiration in Saskatchewan, she recounts the notable difference and strict requirements of Ontario, specifically the need for an employer's letter. Marlyn commented:

I want my OHIP that time, but I really can't because there's lots of requirements because in Saskatchewan, what I also remember is even if it's expired, they will still give you the card, but here [in Ontario], oh no, they really want the employer's letter in order for you to have it, they want to make sure. For example, your work permit is what really you're entitled to, to show that you're here in Canada legally because if you're not with your employer, they want someone to pay for that so it really sucks. It's really tough, you're dying already but you don't even have the chance.

She also drew a distinction between what she believed a TFW is truly entitled to and what they in effect rely on their employer for as verification of their working status to the government. As Marlyn illustrated, the program fosters a dependency on needing an employer to prove a TFW's worth and ensure the value they provide in the country. Without proof of generating this value for a Canadian employer, a TFW's health, security, and well-being can be quickly jeopardized.

Asking employers for letters of employment was even more difficult without clearly outlined instructions stating what needed to be stated within the letter, which also had the effect of making it easier for employers to refuse to provide the letter. The transition period between finishing the program and waiting for an open work permit was often a tenuous time to navigate relationships with employers who worried that some women would decide to leave and could become resentful and vindictive. Jenny explains how her employer refused to write her a letter after years of working with the family and being accommodating of their needs, especially when she began working for them:

The girl [employer], when I got my open permit, I need to open my OHIP, she didn't give me my employment letter, so I didn't claim my OHIP yet. I asked her because I gave her the list of the requirements and it says there the employment, you know what she said? "If you were still working with me for six months, I would give it to you, but you're already going out so I'm not going to give you." I told her, "I worked with you for almost three years now" and then she said, "No, it says here, it needs to be working with them for six months" why didn't she consider me working with them for more than two years, right? Here's the thing, I started working with them just illegal and then I got my work permit, that's legal.

I worked for them outside for April and then I got my work permit, so until July.

Another point of difficulty concerning acquiring an employer's letter was the specificity of types of employment that would be accepted. Once Melissa completed the LCP, she was finding some success with entrepreneurial work in cosmetics, but decided to go back to caregiving work solely because she wanted to secure OHIP after getting into a car accident. Melissa spoke at length about her numerous attempts at applying for OHIP as

she was still working independently. Even with an open work permit and a letter from the company she was working with, she felt her independence was still constrained despite paying her taxes and maintaining her immigration status. By being restricted in her type of work, Melissa felt that this differential treatment to qualify for OHIP amounted to discrimination and produced feelings of frustration:

I think I went seven times. Whenever I go there, the same person will say “you again!” They said “no, we can’t.” So I went to find a job as an employee because it says only employees because having a business and all that isn’t an employee, so I can’t get covered even though I pay tax...I feel really upset, I feel discriminated. It’s just like “Oh this company, you can’t” like why do you have to make it so personal. I went back again and I have everything, license, passport, OHIP renewal, letter from the company that I’ve been working there for a while, that I get paid by commission.

Shifts in policy at specific periods of time created marked differences in the challenges experienced by women trying to secure OHIP, particularly as they awaited their PR decision. Aura remembered exactly when changes were introduced and how new policies immediately created barriers to getting OHIP. Due to the delays in processing PR applications, many women like Aura had been renewing open work permits for years before they received any updates on the status of their PR application and could observe over time how it became significantly more difficult to apply for OHIP after the introduction of increased requirements, such as the stipulation for full-time employment. Aura remembers vividly:

2013 to 2014 that's when he had so many changes right, that's when we started having problems. There's so many changes when you wanted to get a new OHIP when your OHIP expired. From 2008 to 2012, we don't have problems, once your work permit expires, you get a new permit and you show to them and you get a new OHIP, they'll just give it to you. It was 2013, 2014 when they had these new rules...they told me there's a new rules and they showed me the paper and they said you have to have a letter of employment from where you're working and you need to be employed full-time. I don't have a problem with the letter of employment because they're going to give that right, my problem was I was part-time with them because I have two jobs and both jobs I was working part-time because that's how you get more hours there than when you're working full-time, so that's why for how many months I didn't have OHIP because I can't tell HR to issue me anything to say I'm full-time.

As women completed the LCP and began to live on their own, many women took on multiple low-paying, part-time jobs that were more readily available and accessible to them. In anticipation of their families arriving and becoming the primary income earners for their families, many women strategized that they could work more hours, sometimes even more than full-time hours, if they got several part-time jobs. Again, even with the open work permit and as they paid taxes during the period of "implied status", many women still did not qualify for OHIP without full-time work. Aura recalled exactly when and how she lost her OHIP because she no longer qualified without full-time work after policy changes were implemented:

When my work permit expired in 2014 of June, when I'm supposed to renew my OHIP when I got my work permit that's when there's so many rules in acquiring OHIP...when I was with elder care, I'm part-time with them, but even though I'm part-time with them, my hours is total hours, it's just that I decided to be part-time so that I could juggle my own schedule. When I renewed my work permit June 2014 and renewed my OHIP that's when OHIP was saying you have to have a letter from your employer and then they gave me [a letter] but it says there I'm part-time because I'm part-time right, but it even says she's part-time but having these hours, but the requirement for OHIP at that time is you have to have a full-time status. I wasn't able to renew my OHIP, they didn't give me OHIP.

Changes to the requirements and guidelines for approving OHIP renewals were applied unevenly across administration offices. Some officers reviewing OHIP applications were strict in their enforcement of the new requirements going as far as investigating the full-time employment stipulation even when women presented at offices with different concerns. Due to the differential treatment women received at offices, it became evident that without full-time employment, their OHIP could be taken away at any moment without notice. The increasing restrictions on eligibility for OHIP created another level of bureaucracy that compromised access to health care and further heightened their vulnerability during the period of implied status. Erich describes the effect of the changes:

Now it's even worse right because now when you are waiting for your PR and you have for example, I have a case where someone has a valid work permit right, so she went to the application office* just to update her address and they asked her

whether she's working full-time, she said I'm not working full-time, but I have enough hours, I'm on call and I have another job and then on-call means like it could even be more than 40 hours, but it's not full-time because she's on-call and then what they did is they cancelled her OHIP card right there and then. She only went there to change her address right...

Due to the frequency at which Erich met women who didn't qualify for OHIP due to their part-time employment, she described the limited options the women had to get care and how she would advise them. As Erich illustrates the women's situations and reasons for taking part-time work, she makes clear that it is particularly during the period of implied status that preparing for the impending arrival of the women's families becomes their priority. Their choice of living arrangement, work, and savings are all informed by the anticipated need to find a way to independently support their families and afford the cost of living in the GTA. Given their narrow employment options and their Canadian job experience limited to caregiving, the priority of most women trying to save for their family's arrival was to work more hours across multiple jobs, regardless of the various impacts this would have on their health and access to health care. Erich explains how many of the women managed these competing demands:

I see a lot of them are on-call, day shifts, like PSWs [personal support workers] on-call they pay higher than live-in, like \$12 or minimum so they opt for the on-call one. Especially if you're preparing for the arrival of your family and then they opted for a flexible schedule and then they want to go on live-in but they want to get their own place especially if the family is going to live here. So in terms of support, we usually refer them to community health centres, but now

[because of the demand they go on wait list] or they pay for their medical appointment.

6.3 Navigating care

6.3.1 Delaying seeking care

While women were still working in the LCP, their decision to seek medical care was strongly influenced by their fear of jeopardizing their PR eligibility. Oxman-Martinez (2005) distinguished between “primary policy barriers” described in the previous section and “secondary policy barriers” that more accurately demonstrate how “specific immigration programs influence the social location of immigrant women and how, in response, women construct an understanding of their relative social location” (p. 254). Despite being entitled to provincial health care coverage, women still trying to complete the required 24 months of work to finish the caregiver program and apply for PR are deterred from seeking medical attention because of their fear that any sickness could disqualify their PR application. Several of the women I spoke to decided to forego care until after they applied for PR. Erich spoke about the worry and apprehension women still in the LCP had about discovering any illness they might have while they were still working in the program. She described the extent of their fear as so severe that they would prefer to continue working with an illness rather than risk their PR application. She said:

They don't seek help unless it becomes complicated like they're so scared while they're still in the program. There was even a point in time when it was like coincidence, why they all got sick after 24 months and then we were like, they actually get sick before 24 months, but they seek help only after they've

submitted their PR. There was even a time when we within their 24 months, we organized a clinic providing medical services through the immigrant women's centre in the past, but again they're so scared to get check-up because they're scared they might find something and then that would mean their PR application...especially now, before there's Juana Tejada law, they're not required to apply for the second medical, but now the officer has discretion for all their medical exams, especially if they're applying through the new pathway.

For women in the LCP, the delay to care while in the program was engendered because of the belief they had in the precarity of their PR eligibility. It was clear to Erich that for most of the women she worked with in the LCP, their priority was to finish the program for PR and their health could be managed as long as they could work. She goes on to explain that after the changes introduced in 2015 under the new Caregiver Pathways, it became even more difficult for women to qualify for PR because they would now have to undergo a second medical examination to be eligible for PR.

Erich touched on the initial health status of the women when they arrive in Canada, citing the mandated immigration medical examination they all must undergo in order to be approved to work in Canada. She highlighted that the women are actually verified as being healthy before coming to Canada, however as they delay seeking care, conditions such as cancer, progress with increasing complications. The negative health consequences of not getting timely, preventative care have had irrevocable, devastating effects for some of Erich's clients:

Some of the people already passed [the medical examination] right because some of the people before they come here they get medical right, so that means they're

healthy coming here and then sometimes the cancer will just start in one part of the body, like breast cancer and then it's possible the cancer has spread to the lungs, to the brain, and this is during the period they're still working right, so can you imagine how the effect of waiting for the 24 months, waiting for the processing for it to be submitted, waiting for the processing of the PR.

For women in the caregiver program, the time to getting medical attention is strongly determined by how long it takes them to finish the 24 months of care work. While some may not encounter difficulties with their initial employer and are able to complete the program in two years, others go without care for even longer as they move between employers and wait for new work permits for each new employer, sometimes taking over four years.

The delay to care from fear of jeopardizing one's PR application is compounded by the widespread belief throughout the community that medical information can be shared with immigration officials. The anxiety about using health services was felt strongly by women, especially while they were still working in the caregiver program. While medical examinations for the express purpose of being submitted for immigration review were shared with immigration officers, many women were skeptical of widespread information sharing between health care professionals and immigration officials. Leah encountered many clients who had this trepidation about information sharing:

There's a lot of fear about accessing health care, so that's definitely a gap that we see and even though there are some great services for people without status, if they're on medication, how are you going to pay for your medication? Or a lot of caregivers won't admit pain during their visits because they might trust one

doctor but they're nervous about accessing services and I think because there is so much fear around collaboration between the province and CBSA [Canada Border Services Agency] and immigration.

This suspicion throughout the community had very real impacts on the women's decision to access care, producing significant health consequences. The compounded fear of losing one's PR eligibility due to being diagnosed with a severe illness or being reported to immigration officials created delays to care until an acute episode occurred.

6.3.2 Employer discretion

Employers played a significant role in mediating both access to health services and health care coverage eligibility. Supportive employers were crucial to facilitating both time off and access to transportation for women who sought care during the LCP. Leah explained the various barriers to care that exist due to a combination of work demands, time constraints, lack of transportation, and financial limitations. She described how services could be inaccessible for many of the women, even with OHIP, because the hours of operation for most community health centres do not accommodate their work schedules. Managing the competing demands of their employers as well as families back home that depended on their remittances were more immediate concerns that women prioritized over their own health. Affording the time off to seek care was considered a significant challenge due to both the lost earnings and negotiating time off, which was heavily dependent on one's relationship with their employer. Accessibility of health services was also determined by availability of transportation, wait times, and hours of operation. Leah illustrated how these different factors worked together:

Most of the caregivers are working in isolated homes in suburbs where it might be difficult to get to a community health centre, for example, and also most of them work really, really long hours during the week and don't want to ask for the time off so if the service is only available in the week, then that's going to be difficult. It's difficult to take that time off because money wise, if they have a family, they need money to send home. That's even with health care access and without.

If a woman in the caregiver program is diagnosed with an emergent condition and she chooses to disclose her illness with her employer or she becomes too sick to work, it becomes up to the employer to decide if they want to terminate the contract. As discussed in previous sections, one's eligibility for provincial health care coverage is dependent on their immigration status and maintaining full-time employment, which are both left in the hands of the employer. Due to this complex, interdependent system of qualifying for health care, the employer's decision to continue or terminate a contract can also dictate treatment options and availability of care. Erich explains that under the previous LCP, if an employer chose to let go of a caregiver and the caregiver was unable to work or find a new employer, the only option they had to maintain their immigration status was to file an application for PR under humanitarian and compassionate grounds. She goes on to clarify the impact of no longer having the option to apply for H&C under the new Caregiver Pathways, which left some women she's worked with no choice but to leave Canada. Erich pointed out:

Some employers are very supportive and they allow them to stay, but some are unlucky and then they can apply for humanitarian and compassionate grounds, if they can't complete the 24 months. Now with the new program, you can't do that.

There's no more humanitarian and compassionate grounds. So I see a few cases where the women just went back home.

6.4 Major injuries suffered during LCP

Participants who sustained injuries while still working to complete the program experienced the most significant health concerns that required the most intensive care as well as rehabilitation therapy. Two participants suffered spinal cord injuries, while one was in a major car collision. Due to the unexpected nature of their injuries and their limited physical capacity following their accidents, continuing treatment was a major challenge for each of them for various reasons, particularly the timing of their work permits and OHIP expiration and the extent of social support available to them. The physical effects of their injuries were exacerbated by the stress of trying to secure care, especially given their restricted physical function.

Just after completing the LCP and submitting her application for PR, Gina was let go by her employers even though she was hoping to continue working with them. After being terminated from her job, Gina had no choice but to stay with her sister who also finished the LCP. As she was preparing to interview for another employer later that day, Gina went about her morning routine when she began to feel pain. Gina vividly recalled the morning her injury happened: "My injury happened at 6:30 in the morning. It just happened, I didn't have any accident, no fall, no nothing, it's just a pain in the back of my neck. First, it was just a tingling pain and it's getting worse and then I lost my movement. Yeah and like 15 minutes, it's totally gone. My left side was gone first and then after a few minutes, also my right." Gina attempted to reach for her cell phone when she realized

she really couldn't move and was lucky to be at her sister's place so her sister was able to find her and get help.

Evelyn was still completing the program when she suffered her spinal cord injury. Evelyn was just taking out the garbage on a cold February night when she felt dizzy and fell on a block of ice. When she regained consciousness, she realized she couldn't move and began screaming for help for 45 minutes when her neighbors finally found her. After being rushed to the hospital and then transferred to a specialized trauma hospital, Evelyn alone and confused underwent an emergency operation. After waking up in the intensive care unit, she spoke of the first things that came to mind:

I thought oh my God what's going to happen to me, I don't have family here and the first things that comes to me is "What's going to happen to my status?" ...My level of injury was in the survival area so it was a T5-T6 spinal cord injury. So they took me to another unit of the ICU and then my friend came and I said the doctor wants to meet you because I declared her as my next of kin because I don't have family. So when she came back, I know that she cried right because her eyes were red and I said oh my God.

Since Melissa was rear-ended by a truck, she didn't anticipate the extent of her injuries immediately after the crash. Still in shock after the collision, Melissa described her myriad of ongoing worries that only intensified as she dealt with the aftermath of the accident. She explained:

I was exiting the highway*, I was slowing down because of the traffic and a guy just hit me. It was a truck, but I'm ok, but after that, I'm not ok because I don't

know what I'm doing. It's really because I'm so worried about my papers, my daughter, and then my accident, so it's a disaster and then I don't know what I'm doing, I got a lawyer and I know it's not my fault...after a week there's a pain. You don't feel it right away, but there's headaches. At first my back, my upper right arm. The car is almost crushed, that's why the impact is so hard.

For both Evelyn and Melissa, after the realization and the extent of their injuries slowly set in, their most immediate concern was how their injury would impact their immigration status, securing PR, and successfully sponsoring their family. Despite their life-threatening circumstances, they both instinctively were more concerned with their priority of maintaining their status and remaining eligible to sponsor their families.

Following their accidents, the effects of the injuries they sustained were exacerbated by the stress and fear of losing health care coverage and consequently, stopping treatment. Immigration status remained top of mind for all three women for the purposes of sponsoring their families, however the realization of how their immigration status, work permit, and OHIP worked together was not always immediately clear. Months after Evelyn and Gina were no longer in critical condition and they were beginning to cope with the shock and trauma of paralysis, they discovered their therapy and treatment could stop. Evelyn clarified what and how she came to understand her circumstances:

When you're a live-in caregiver or any foreign worker, when your work permit expires, everything else expires too. They have the same expiration, your OHIP, your SIN. So when I found out oh my God my OHIP expired together with my work permit and I already forwarded my documentation to the CIC, I know that I'm

covered with an implied status, but I didn't realize it's going to affect my treatment without OHIP, so when I told my physiotherapist that my OHIP expired, she was in panic mode and then I told her what will I do and she said I don't know.

Evelyn goes on to describe how she felt once she realized her therapy could end at any moment during such a critical time of rehabilitation. The hope of regaining any movement through therapy was suddenly threatened once Evelyn realized how implicated her health care coverage was to her work and immigration status. She said:

I was so scared, really really scared because this is another thing happening, right? Before that I was scared of my status because it's going to expire and then good thing they have what this is called implied status for the expiration if you file your application for permanent residency, including the open work permit, it's ok so long as they receive it before the expiration. I don't know now, but I'm under the implied status, so I'm covered, so I said oh, they won't send me back home, but then I realized about the OHIP when I had that shocked reaction from the therapist, I was so scared because they can stop my treatment right...what if I don't have WSIB? That's the problem. From July to November, my treatment would have stopped. And during that time, I really have to push myself because with spinal cord injury, they said you have to push and work really hard during the first year.

Evelyn went on to explain that because her employer was a social worker, she was very aware of her responsibilities as an employer and was sure to purchase WSIB for her as soon as she was hired. Evelyn was very fortunate that she was one of few women in the LCP whose employers willfully purchased WSIB for the duration of her employment.

Due to the severity of her injury and the long-term therapy needed, Evelyn's OHIP expired during her stay at the rehabilitation hospital when she was clearly unable to return to work and therefore ineligible to renew her OHIP. Without OHIP and the possibility of working again, losing coverage at the rehabilitation hospital not only meant stopping treatment, but also meant the risk of being discharged from the hospital and becoming homeless. As Evelyn scrambled to get help and appeal her OHIP renewal, her care team was able to establish a claim with WSIB to cover her stay as well as continue her treatment. Since Evelyn struggled to find any assistance to renew her OHIP, her ability to claim her workplace injury through WSIB proved to be crucial to her recovery.

Gina was also continually reminded by her care team that they would have to stop her treatment if she couldn't renew her OHIP. The fear of not being able to renew her health care coverage only compounded Gina's fear of total permanent paralysis:

Every time we spoke it's like "the OHIP is going to expire". They told me, if we didn't do anything, they'll discharge me soon. That's the big problem that we encountered...I'm scared, I feel depressed and then how...I don't know, it's just like every time we have that meeting, the OHIP always comes up because they told me they cannot do anything, they cannot do anything...My work permit is still valid until September, that's why my OHIP also is until September.

As they tried to manage the pain and cope with their limited physical capacities, advocating for themselves was even more challenging. Melissa's physical health as well as her financial status was compromised by no longer being able to work and losing her health care coverage during implied status. In pain, Melissa paid for care out-of-pocket

for a limited time until it became absolutely unaffordable without an income. After managing her pain along with the stress of losing her health coverage, Melissa was then refused permanent residency. She described this period of her life:

That was the most down moment in my life, I really stayed down. I have no job, even if I want to go to work, I don't feel good, I'm in physical pain, so what can I do? But then I have to fight... I feel hopeless. I have a lot of things on my plate. I feel pain, I don't have OHIP, I don't have coverage, every time I go to the hospital I pay and then they said I can't get my permanent residence, I just literally dropped all my papers, like what I don't have coverage right now. You know how you feel depressed, I can't work, I can't focus, I had to take a step back from my business, so I don't know how I'm going to survive.

While Gina and Evelyn were able to be admitted to hospitals immediately after their spinal cord injury, they were both constantly reminded that their treatment could stop at any time once their OHIP neared expiration. Both of their care teams were aware of their circumstances surrounding their immigration status, employment, and OHIP expiration, yet no health or social service professional offered their assistance in helping them find a way to continue their health coverage. Gina and Evelyn both spoke at length about the lack of appropriate support available to navigate continuing care during the most critical period of aggressive rehabilitation needed following their operations. Both women remained immobilized as their care teams reminded them of the possibility of stopping treatment if their OHIP expired without providing any guidance or support to explore how they could look into extending their coverage. The lack of resources, coupled with the continuous warnings from their care teams, produced significant fear and anxiety for

them as it would have numerous consequences, including the possibility of permanent total paralysis. Gina explained:

Even my social worker at the time, they didn't do anything, they just said that's a big problem...I was so depressed at that time and even my sister took vacation time to try to renew my OHIP. It was a very struggling time in my life before...when I was at the hospital, they wanted to kick me out because I don't have OHIP. Even my doctor said that if I can't renew my OHIP, they have to discharge me. I was still in my trauma and she always tell me, they're going to send you home.

Evelyn considered the numerous consequences of being discharged and questioned how she could possibly survive. After incurring the injury at work, Evelyn knew she could no longer go back to living with her employer and had no family to stay with or depend on for her help. For Evelyn, being forced out of the rehabilitation hospital also meant becoming homeless. She recounted:

During my time, I think it's supposed to be three months, whether you're better or not, you have to go. So I was told to go, but where will I go. First, I'm still not well and I need rehab. Secondly, where will I go? My employer can't take me in because I haven't worked for them already. Who's going to take care of me? My friends cannot take me in, it's not possible. They're not responsible for me right, they have their own life. So I was like where will I go? I'm going to be ending up in the streets, where will I get money for my food.

With still extremely limited movement and feeling only in her fingers, Evelyn requested a laptop from the rehabilitation hospital and independently searched on the Internet for

resources. After seeking legal assistance, her lawyer informed her that despite agreeing to help her with her immigration forms and PR application, they would not be able to provide any support in terms of her health care coverage. She recalled:

When I told them [lawyer] that my OHIP expired, they said it's not part of their job. I said it's part of our contract that you're going to help me with my open permit, my permanent residency application, plus the OHIP. They said you have to do it by yourself, so I was like what am I going to do.

After Evelyn's lawyer refused assistance with her health care coverage, Evelyn turned to a neighbourhood settlement office for assistance. As she phoned from the rehabilitation hospital, the settlement counsellor she spoke with was reluctant to offer any advice or take her case. She remembered vividly:

So when I called the lady, she was telling me that she couldn't help me. So I begged, I begged over the phone, I was so...actually I had an anxiety attack during our telephone conversation, I was begging and crying and really crying hard, and then finally she told me ok, I'm going to ask around here and I'll give you a call. So the next day or two days after, someone called me and he said oh your case was forwarded to me.

The lack of availability of both health and social service professionals within the health care system as well as throughout settlement services who could offer any advice for Gina and Evelyn's situations nearly meant stopping care for both of them. While Gina and Evelyn were both still patients in health institutions and were being seen by providers as they attempted to navigate extending their health care coverage, Melissa felt she had

no choice but to pay for care out-of-pocket. Following the initial shock of the car collision, the residual impacts of the crash left her in significant pain. Without any benefits, limited coverage from her car insurance, and after stopping work due to the pain, Melissa sought limited therapy before being unable to afford it. She explained her situation:

I need to [go to physical therapy], but I can't afford because I don't have a job. I still have a lot of pain, constantly every day I complain to my boyfriend, but there's nothing I can do. It's so much pain I can't even work. He said that the insurance won't even approve you for another physio.

6.5 Cancer

Key informants working with groups across the community, settlements services, and in grassroots organizing all regarded cancer as a major issue among their clients and members. Leah had only been advocating for caregivers for a little over one year when we spoke and recalled, "In nine or ten months, five caregivers who have breast cancer." Erich had been a settlement counsellor for almost ten years and witnessed numerous changes to the LCP and its administration. In discussing the health of her clients in the LCP broadly, Erich highlighted cancer as a major problem throughout the community. She remembered a particular period of time when numerous clients were diagnosed with cancer: "At that point 2014-2015, like those were really, really bad and maybe like 4 times a year, like those high profile cases we work with. Now we see them a lot because there's now more awareness in terms of where they can access resources like they go directly to health services." Erich distinguished the frequency of cases that she personally dealt with years ago and noted that now people seem to be more aware that they can

access care. She went on to speculate that at the same time, processing between closed and open work permits as well as PR applications was particularly long and may have contributed to confusion around entitlement to care as well as delays to care.

As stakeholders across different community groups, key informants were quick to recall cancer as a major issue among their clients and while they could clearly see the pattern over time, they all acknowledged that they could not draw a direct correlation between care work, the program, and why so many women in the LCP got cancer. Over his seven years in grassroots organizing throughout the Filipino community and with migrant workers, Paulo observed:

We've had a lot of caregivers, about four or five, over nine years, there's been an issue of caregivers getting cancer and Lucy* passed away in 2013, she had breast cancer. Juana Tejada had cancer too. There's two others... We as organizers, we don't know... there's no direct causation to say it's because they're involved in this kind of work, but you look at the workers and you can see they're so stressed, no status, working six days a week, that of course contributes to stress and getting cancer.

Some settlement workers, such as Cora, tried to assist clients as they got cancer treatment. Often without any immediate family or friends in Canada, settlement workers struggled to help their clients with various aspects of their lives, including navigating their care, immigration applications, contacting family abroad, and finding them housing after discharge. Cora explained how she had to first understand the context of each client's situation and how there were often few options to negotiate their care, which was

heavily dependent on their immigration and working status within the LCP. Explaining how their work, immigration status, and health care coverage were all interdependent was a challenge in itself for many community workers who were faced with the task of making clear how precarious their clients' situations were. Cora told the story of one client:

She was in her 40s, but what happened is that Jane* was recruited by her sister in-law. Her sister in-law is here and she told me she doesn't want to come to Canada actually because she worked in Hong Kong for 15 years...when she was admitted, she was at stage 3...that time it was July, the OHIP and the work permit expires September...The thing is, she was out for work for years, I don't know why it took so long for her to complete the 24 months and find another employer...The nurse told me we cannot accommodate her because we're not a housing building and we can't have somebody stay with us, in other words, for her to be discharged from the hospital*, she needs a house, somebody needs to take care of her and then she was saying where can she stay? ...she doesn't understand what's going to happen when she loses her OHIP when the OHIP is expired, how is she going to renew if she doesn't have an employer?

Victoria was a lawyer with both a research background on the Canadian LCP as well as experience representing clients in the LCP. After completing academic research on the LCP, she continued to practice immigration law with many of her clients coming from the LCP. She recalled the beginning of her practice when women in the LCP frequently sought her help specifically because they had cancer. She illustrated how each case varied

between how advanced each woman's illness was, the time they had worked in the program, and their family's situation:

But there was also a time in the first few years of my practice when the caregivers themselves were deemed inadmissible because they had cancer, they were diagnosed with cancer while here. Until they had the Juana Tejada law. There was even times when I saw them when they were dying, but they desperately wanted to get the PR for the family members. Some of them survived long enough to be able to get the PR. Sometimes, caregiver dying, granting them permanent residency, they didn't agree, there's a few cases. Then there was some where it was much quicker so the caregiver could be granted PR so the family members can come here. That happened, but there were some heartbreaking cases where they died before they were going to be granted permanent residency and the family members are here already taking care of the dying caregiver, so we tried to apply for permanent residency under the caregiver class, but with humanitarian and compassionate claim, few were granted, others were refused, so they had to apply after the principal applicant was passed. The family members had to apply on their own for permanent residency on humanitarian and compassionate grounds. That happened at least ten times because these cases kept coming my way, so we tried, for some they were successful in the sense that the family members were granted PR because the caregiver finished the two-year requirement and also before the Juana Tejada law, they were granted exemption to the excessive demand for the principal applicant.

Victoria demonstrated how subjective the treatment of her caregiver clients was, despite their critical conditions and many facing similar circumstances with their families. She described how the discretion of immigration officers became paramount, especially for her clients who had cancer, but weren't able to complete the 24-month work requirement to be considered for PR. Victoria outlined the factors she would try to highlight to argue each case for her clients applying for humanitarian and compassionate grounds (H&C), such as their involvement in the community and relationships with employers. Ultimately, immigration officers exercised their judgement subjectively and decisions could be inconsistent. She explained:

Some of them, they didn't finish their two years, so that matters to some officers. For some officers, it was easy enough for them to be granted H&C because the caregiver completed the two years, but some of them contracted cancer and were unable to finish the two years, it was much more difficult so we had to provide stronger H&C grounds, if not, they were refused, if they were not established enough, or there was not enough support from the community or from the employers, they were not as successful. The Juana Tejada law came after that.

Victoria alluded to the importance and impact of the Juana Tejada law after experiencing mixed success with filing H&C claims for so many clients prior to its implementation. She saw cancer as a widespread issue throughout the community as she stressed the frequency and magnitude of cases she received precisely due to women in the LCP being diagnosed with cancer while in the program or discovering they had cancer as they submitted their PR application. Concern over the changes introduced with the creation of the Caregiver Pathways, including ending the Juana Tejada Law and effectively re-

establishing the second medical examination requirement for PR applications will be discussed in depth in subsequent chapters.

6.6 Mental health

The mental health of women in the LCP and currently working as caregivers was also highlighted as a major concern by health and social service providers, while women spoke of feelings ranging from stress and anxiety to depression and trauma.

Understandings and expressions of mental health challenges and positive coping strategies varied between key informants and those who worked as caregivers. The unique challenges impacting mental health included prolonged family separation, lack of privacy, de-skilling, and traumatic events relating to their ongoing precarity.

Key informants noted the significant influence sociocultural beliefs and values had on the mental health help-seeking behaviours and presentations of women in the LCP. As a family physician from the Philippines who continues to work with Filipino clients, Robert remarked about women who worked as caregivers specifically, “Almost half of the time they present with mental health problems.” Robert emphasized not only the frequency at which caregivers presented with mental health problems, he also distinguished mental health as their main concern. Robert expanded:

Depression, anxiety, mainly those because those are mental health illnesses that are due to pressure in life. Mainly those are adjustment reactions like something happened and they were not able to cope and it’s manifesting in critical symptoms that are somatic because they don’t understand why and if I dig deeper into what happened recently, then they would divulge. In those cases where they don’t tell

me, eventually they would go to emerg and then see someone else and then they would tell that person that this is what happened. So I ask four or five times and they never tell me right, but maybe because they already have a relationship with me they don't want to tell me that they're having all of this like their husband is having an affair so I just find out later that those symptoms were because of that.

Robert spoke at length about the difficulty and challenges he had when probing for not only the medical history of his patients, but also factors or events that may have prompted or worsened their mental health status. Contravening cultural values and or expectations, particularly with respect to family and relationship issues produced intense feelings of shame and embarrassment so strong that women were extremely reluctant to disclose their difficulties. Women experienced somatic symptoms so severe that they would seek care at emergency rooms, yet upon seeing Robert they still refused to accept the possibility they were experiencing a form of mental distress.

In response to the resistance to diagnoses that Robert encountered, he ran several medical tests to rule out physical conditions on the insistence of his patients. Since Robert also had a Filipino background, he had the cultural capacity to understand the unique stressors some of the women were facing especially with respect to managing their family and marital relationships in the Philippines. Combined with the cultural stigma surrounding mental illness, Robert understood the necessity of practicing cultural sensitivity not only when he explained the nature of mental health, but in getting patients to share life events that may have triggered intense emotional responses. Despite the hesitancy of some patients to accept their diagnosis, he describes it as critical to their care in order to get them to comply with treatment plans for extended periods of time.

It's hidden. You just have to dig deeper in terms of what's causing it, so the first thing is that it's not always a medical problem, but upon further questioning and doing the tests showing that everything is fine and then they'll say they've been to emerg three times already and the tests they do at emerg, they're all negative and then you'll see maybe there's a mental stress that caused it and then sure enough there is. And then sometimes it takes a while for them to realize that yes, it is a mental health problem and that they would agree to taking the medicine on a long-term basis like anti-depressants and anti-anxiety medicines, it takes a while to take effect, maybe six to nine months, it's not like an antibiotic that you can take for one week and then that's it.

Robert went on to explain the severity of the symptoms some of the women in the LCP were facing due to unmanaged mental health issues. He saw the challenge of explaining their mental health condition as critical to their care, otherwise their refusal to accept their diagnoses resulted in serious health consequences and a continuing decline in their mental stability. Robert explained how the physical manifestation of their stress and unresolved emotions expressed through their bodies can sometimes make things more confusing:

It's difficult because it's not a tangible diagnosis. If you explain to them that those events in their life then they would realize that those events could cause symptoms but sometimes it's difficult for them to accept they're getting into depression or anxiety because they're having these panic attacks. Those are the cases where you really have to explain it well so that they would understand and they would always say that we've done the tests to make sure it's not a heart

condition or other medical condition and I think this is the reason why you're having it and then sometimes it will take time for them to accept that diagnosis.

During periods of heightened vulnerability, some women experienced events that caused undue stress. Carmela's experience of being "released upon arrival" was particularly traumatic after she was deceived by the recruiter who helped her come to Canada. After picking up Carmela at the airport, they went to visit a prospective employer, and soon after she locked Carmela's belongings in her garage. The recruiter told her she would just drop her off at a mall so that she could pick up a few things and never returned to pick her up. Stranded at the mall the day she arrived in Canada without any friends or family in the city, Carmela was panicking when remembered she met another woman who was also going to Toronto when she was getting her medical examination done in the United Kingdom and added her on Facebook. In desperation, Carmela messaged her on Facebook. Carmela reflected on her decision to reach out to this woman who she barely knew:

So I went [crying] and it's crazy because I don't want to go with strangers, but I have to carry on. I said to myself, I can't just check into a hotel and be alone, you might just lock yourself in there and commit suicide because who knows, you're getting crazy. No one is going to tell you you're doing the right thing, but you just have to get on. Somebody needs to be with you, just shut up and be beside you. That's what I needed at that time. So I stayed for almost a month because I don't want to go out, I was just getting crazy and very, very worried. I cried every day.

In the moment, Carmela immediately recognized the traumatic feelings she was experiencing and her need to not be alone. Without any other support available, Carmela was well aware that she was potentially putting herself in an even more vulnerable position by taking another chance on staying with people who were virtual strangers to her. Ultimately, Carmela prioritized her need to not be alone over her fear of staying with people she barely knew. After overcoming her initial trauma of being left stranded after arriving in Canada, Carmela continued to have extreme difficulty finding an employer and faced numerous violent clients. Carmela was still trying to complete her 24 months of work to apply for PR at the time of our interview as she described the lasting effects of the trauma of being released upon arrival combined with her violent clients:

It's like I get scared easily, it doesn't matter how hard the situation is, it depends on how vulnerable you are, it's not just about the war...it's about how your mental health is...it's a very thin line actually, how much you can tolerate, how vulnerable you are, how much you can tolerate the abuse, how much you can tolerate every experience you have in your life, so I said to myself, all of you here in Canada, the caregivers, congratulations if you pass the test because you're very tough. I won't even say to a stranger that it's easy, all of you are very tough.

Time between or without an employer marked periods of profound stress and vulnerability for women. Reasons for being without an employer varied, ranging from being released upon arrival, a client passing away, being let go, or being replaced. Patricia worked with her employer to schedule time off to go back to the Philippines to see her family. They agreed that while she was away, they would arrange for somebody to come in on the weekends to look after her client while she was gone. Upon her return,

Patricia discovered that she had been replaced without any notice or reason for termination. After spending her savings during her time back home with her family with the expectation that she would return to her job in Canada, Patricia felt extreme pressure to find another job immediately. Patricia was manifesting her stress physically when she decided to see a doctor. She recalled how she expressed her somatic symptoms in light of her unexpected circumstances:

My reliever for the weekend took my place, so that's a bad thing because I came home from everything, I don't have money. Maybe I was so stressed that time, I always felt dizzy and I can feel chest pains, so I went to the doctor. He said it's only stress because maybe you're thinking so much because of your job, because of what happened to you now, but then after he advise me to get enough sleep, drink more water, but he didn't give me any medication, only stop thinking too much, relax, have a good sleep. They checked everything. They asked me to have my ECG, blood test, everything. They said everything is good.

After moving between employers for years, Marlyn shared her feelings of suicidal ideation. Marlyn explained at length how difficult it was to not only find a new employer, but to then ensure they would process a new work permit for her. She recounted many employers who she worked months for that lied about being in the process of submitting an application to file for a work permit for her. Her frustration with these employers was not only for their deceit, but because they wasted the limited time she had to complete her two years or 3900 hours of work within four years of beginning the LCP. Marlyn was very conscious that her time to finish the program was precious not only to secure her PR, but for her prospects of being reunited with her daughter by bringing her to Canada.

In spite of the pressure and stress she felt about finishing the program and how she was taken advantage of by her employers, she keeps in mind her ultimate goal. Marlyn described her motivation to persist, “I’m four years now and my employer is processing, it’s still a problem. I also cry and I want to die...if only I don’t have daughter, if not, who will care for her? She has no father, I don’t have mother too, but I’m lucky.”

Other women spoke of feeling depressed and experiencing other depressive symptoms, such as persistent unhappy moods, frequent crying, insomnia, and feelings of perpetual loneliness. Unlike those who experienced intense stress triggered by instances of heightened vulnerability or traumatic events, prolonged separation from families and support networks also produced strong feelings of generalized depression. Depressive moods were most pronounced when they felt their families had become emotionally withdrawn or indifferent about their lives. The length of time some women had been apart varied widely from six months to over thirteen years giving rise to mixed feelings and strategies to maintain relationships with those back home. When women desired to remain involved and close to their families, feeling estranged or ignored by their children and spouses resulted in extended periods of overwhelming sadness. Struggling to maintain a close relationship with children and husband, Lita lamented:

I feel depressed. I cried. I will just cry and say no one loves me. I will just walk and say my life is so boring...I have nothing to do there. I just want to cry. I feel down, I don’t know. Sometimes, my brain cannot pop up what I’m thinking, I’m just blank. I just work, work, work, work. Sometimes, I want to sleep but I’m too tired, I cannot sleep. Sometimes, I talk to my mother in heaven...Being a caregiver, sometimes you are so tired, you really don’t want to work, but you force work,

even though you miss them so much, sometimes you will ask attention from them in the Philippines, like my husband...I asked some of my friends before in the Philippines and they said “But that’s our role. We’re the one sending money, we are the one who are taking care of their financial, but it is still our fault if something happens...It’s good for them because they’re there, they’re free, they have a lot of things to do, they can do whatever they want to do, they can go wherever they want to go, not like us here, we’re inside the house, we have no one. After the work, if you’re a live-in caregiver, you will see inside your room.

Despite recognizing distinct emotions of sadness and loneliness, Lita still had difficulty accepting her feelings as depression. Lita slowly came to terms with the possibility that she may be experiencing depression only when her moods began to impact her daily activities of living, such as sleeping and cooking. During times of noticeable dysfunction, Lita’s only solace was in prayer as she reflected:

Because I don’t know what depression is, I don’t even know what it is but over time, I told myself, this is depression already because I want to cry, I cannot cry, I want to cook, I have nobody to cook for because I’m alone there in the mountains. Then I feel so down, I don’t know, but I can manage it because I always remember what my mom told me “Just pray because God is always there for you, He will guide you.”

Etta worked as a counsellor for women in the LCP as well as other newcomer groups for years, although she distinguished the unique emotional challenges caregivers grappled with. Etta highlighted the irony of the situation many of the women she counselled found

themselves in and the sadness they bred from taking care of other people's families, but not their own. This was particularly difficult for some as they dealt with grief from the loss of loved ones back home they couldn't care for or see in their last days. Etta spoke of the common struggles the women shared:

Emotional, psychological issues, being apart from their families and taking care of kids the same age as their kids back home is hard for some women. Looking after seniors in the seniors home when they cannot look after their own parents back home who are dying is quite hard. When they go home and they see their mom and dad in the ground, the remorse is really tough. You hear things like "I can't look after my mom back home because I'm looking after the seniors here and my mom's dying back home." The emotional trauma and the psychological aspect is there.

Several participants expressed their longing for a space where they could feel free to be who they are and distinguished between their employer's house or weekend apartment from their homes in the Philippines. Despite finding a weekend apartment she shared with numerous other women working as caregivers, Lita divulged how complacent she still felt at times. Lita spoke at length about her feelings of despair at not having a space she truly considered her own:

That's why you feel so sad because we don't know where to put ourselves. That is one of the saddest feelings, for me. I sleep outside the house, I can't sleep inside the house when friends are there, I have to wait until the friends are gone. They

are drinking, laughing, we are also talking to them but deep in your heart, you really want to rest.

Despite the reprieve she hoped for on her days off and at her weekend apartment, the small shared place was still a contested space between roommates and their guests. Negotiating food and sleeping times with her roommates' activities was still another challenge she had to manage. Lita spoke of the toll this took on her:

Sometimes it's really depressing, when you are happy because you'll rest for two days, but you are unhappy because you have no privacy. You will sleep there, unless there are visitors, you cannot sleep...we have no privacy because you're in the couch sleeping there and their apartment is too small. I will rest, but if I will be there in the apartment, no privacy and you cannot save because you have no room if you buy food, we will share everything because you have no room right...When I was there, no privacy, everything that is bought is just gone.

Patricia described the difficulty of establishing social boundaries with the children she cared for, particularly because of the emotional attachment the children had to her over time. She explained that enforcing rules to persevere her own space was challenging because it was sometimes confusing for the youngest child she cared for to understand her need for separation. In desperation, Patricia shared some strategies she used to create a space for herself in response to the child's protest:

"No tita [auntie], you're not leaving!" even if I need to get dressed and he needs to get out of my room. Even if I don't have any plan of leaving! Sometimes I just need to wait in the park if the son when they're already in their room, then that's the time

I need to go back. It's difficult for me because it's like I'm now the mother for them. One thing is, when the mom is not there, he calls me mommy, I said "No! Don't call me mommy! Your mommy might get mad with me!" he said "You're my mommy! My mommy is not always here, you're my mommy!"

6.7 Discussion

This chapter addressed one of the central research questions of this study: "Within the context of transnational migration and employment, what kinds of health needs and challenges do the women experience and how do they address such needs and challenges?" The experiences of many of the women demonstrate the various ways in which they manage their health in light of their own competing priorities to secure theirs and their family's PR status through completion of the program, maintain employment, and financially support their families back home. Their decision to seek care was often strategically weighed against the degree to which they perceive it will jeopardize these goals. The fear of compromising their PR application if a condition was diagnosed was frequently cited as a deterrent factor from seeking medical attention and for delaying care. Confusion surrounding information sharing between medical professionals and immigration officers was highlighted by key informants as a key reason their clients were discouraged from getting care.

As women moved between immigration statuses, the consequences for their health care eligibility were not always apparent. Due to both the uncertainty and lack of awareness surrounding entitlement to health care and the protection of privacy, many women decided to delay or forego care. In the event of an injury or emergent condition, accessing health services and continuity of care was determined by maintaining health care

coverage eligibility, which was dependent on both full-time employment and remaining in legal immigration status. If women suffered a catastrophic injury or required long-term care for chronic conditions, such as cancer, where they were unable to work, they would fall out of their temporary immigration status and eventually lose health care coverage simultaneously. There were limited avenues of recourse to appeal their denial of care or the renewal of OHIP, if women were able to find assistance to assert their case to the MOHLTC at all.

Due to immigration policy changes to the LCP as well as the difficulty many had in understanding health care coverage eligibility as women moved between immigration statuses, managing their health was constrained by sets of complex policies that were intricately woven together. As changes were introduced to effectively end the LCP in 2015, the dissolution of the Juana Tejada law and the reestablishment of the second medical examination for PR applications instilled renewed fear about seeking medical attention throughout the community. Both real and perceived threats around information sharing between immigration officials and health care professionals strongly influenced the decision to engage with the health care system. Discussions with key informants also highlighted how difficult it would be for women who are diagnosed with chronic conditions to make a claim for PR since the 2015 changes also took away the option of filing H&C. They speculated how these changes would make it all the more problematic for women to even consider seeking care at the risk of compromising their chances for PR. Those working in the community prior to the Juana Tejada law vividly recalled the magnitude of women they met with advanced illnesses precisely because they avoided being diagnosed. Many anticipated the changes would give rise to similar health

outcomes they witnessed before the Juana Tejada law as women's precarity was further entrenched without the formerly guaranteed pathway to PR and the need for a second medical examination.

Women experienced significant levels of distress stemming from various stressors arising from their precarious status and working conditions, compounded by their extended separation from their families. Traumatic events, specifically the experience of being released upon arrival as well as being let go from an employer, triggered acute feelings of vulnerability. Women discussed the fear they felt knowing they had no support network, limited transportation, and nowhere to live as they looked for another employer. Families played an ambiguous role as many women refrained from sharing with their families the true extent of the challenges they were facing. The shifting dynamics of their relationships with spouses, children, siblings, and parents could also be strained causing significant social, emotional, and psychological anxiety. This was particularly the case for women who participated in previous labour migrations in other countries often culminating in over ten years away from their families resulting in the dissolution of marriages and estrangement from their children. Women with multiple labour migration experiences expressed strong feelings of loneliness and generalized depression. Lack of privacy or a space truly for themselves also contributed to feelings of depression as many women longed for a place to call their own and that they could control boundaries and terms of away from the purview of their employers.

Chapter 7

7 Discussion and conclusion

7.1 Introduction

This thesis is based on a critical ethnographic study that included data collection in the Greater Toronto Area (GTA) and Manila, Philippines. The objective of the research was to explore how intersecting vulnerabilities, related to socio-cultural isolation and familial separation, may produce health disparities among migrant care workers in the GTA. The study aimed to address the following questions:

- How have policy changes to the live-in care program (LCP) impacted the transnational migration experiences of Filipino women live-in migrant care workers?
- How do the women navigate and juggle the competing occupational needs of their Canadian employers and the socio-economic and/or health needs of their families at home in the Philippines?
- Within the context of transnational migration and employment, what kinds of health needs and challenges do the women experience and how do they address such needs and challenges?

The purpose of this chapter is to situate the most significant study findings in relation to the empirical literature that has informed this research and to demonstrate the ways in which my work both aligns with and extends current scholarship in the key areas/fields of labour migration, migrant health, and care work. The first two sections involve private recruitment processes, specifically the de facto approach for temporary labour recruitment in Canada and the long-term consequences of illegal recruitment. Next, I explore how my findings about the extended precarity produced by the LCP informs the literature on the mental health of migrant care workers and the well-being of their

families. In addition to this, I outline the implications these findings have for future migration research, policy considerations for the protection of migrant workers, and health and social service provision for migrants between permits (i.e., awaiting immigration application decisions) or without status. Towards the end of the chapter, I also engage in a critically reflexive assessment of the impact of this research on my lived experiences and social location as a researcher.

7.2 Situating the key findings

7.2.1 Private recruiters as the de facto approach to accessing the Canadian labour market

Within the global literature about recruitment of migrant workers, dominant themes focus on regulating labour recruitment to prevent human trafficking (Agunias, 2010; Andrees et al., 2015), the exploitation of workers (Faraday, 2014; Varona, 2013), and the role of migrant brokers as a first step to initiating transnational migration across Asia (Lindquist et al., 2012). My data confirms these themes, however, it also adds to the emerging literature on stepwise migration (Paul, 2015; Paul, 2017) within the Canadian context. In Canada, temporary foreign workers must be sponsored directly by an employer, however, the literature has paid less attention to how employers are found (Oxman-Martinez et al., 2005) and connected with prospective workers abroad. My data contributes to research on how migrant networks and recruitment agencies shape migrant labour flows between destination countries. My research demonstrates the pivotal role recruitment agents can play in accessing employers, however, the mechanisms through which they operate and facilitate immigration to Canada needs to be better understood. As recruitment agencies and other non-state actors continue to operate both in Canada and overseas with minimal

oversight, they effectively structure and link different destination countries together (Paul, 2017).

Largely operating within Canada, these recruitment agents structured and managed entry to Canada without oversight or reprisal. Paul (2017) notes how these industry actors are effectively “initiating and enlarging transnational connection between destination, rather than just between origin and destination” (p. 240). As non-state industry actors become the de facto approach, more attention should be paid to “stepping stone” destinations and how they shape the trajectory of migrant workers. Faraday’s (2014) report magnifies the repercussions of this less studied phenomenon of stepwise migration in destination countries, such as Canada, describing it as a “lengthening of the recruitment chain” that makes it even more challenging to trace accountability.

Illegal recruitment fees paid by migrant care workers was the normative pathway to enter Canada. My research demonstrated that it was common practice for illegal recruitment agents operating within Canada to act as a gateway to Canada by establishing their services costs to process employer contracts in order to enter through the LCP. The lack of recourse against illegal recruitment fees borne by prospective temporary foreign workers has allowed recruitment agents to persist and expand their fees and services for other temporary residents, such as international students. For the women in my study who paid illegal recruitment fees to work in the LCP, their main priority was permanent settlement for themselves and their families. Taking action against fraudulent agents took away from their limited resources and time to complete the LCP. Migrant care workers feared their eligibility for PR would be compromised, if they spoke out against recruitment agents or were perceived as complicit in any illegal activity. The risk to their

and their family's future far outweighed any potential benefit of recouping the illegal recruitment fees they paid.

Enforcement of recruitment laws under the *Employment Protection for Foreign Nationals Act* (EPFNA) and protection from illegal and fraudulent recruitment requires coordinated action by both federal and provincial governments. In Ontario, there is minimal legislative enforcement of EPFNA and no proactive protection through registration or investigation of illegal recruitment practices (Faraday, 2016). Other provinces, such as Manitoba and Saskatchewan, are more developed in the implementation of legislative frameworks that are proactive in the protection of migrant workers. The failure to protect against illegal recruitment in Ontario produces cascading effects that undermine migrant care workers' rights throughout the trajectory of their migration and strongly influences their working conditions.

On November 23, 2021, IRCC announced the opening of the College of Immigration and Citizenship Consultants as a step towards reducing immigration fraud. The College became the official regulator of immigration and citizenship consultants across Canada with the power to investigate professional misconduct and discipline its licensees. It remains unclear at this early stage what effect the College will have both in stopping and deterring fraudulent recruiters. International UN rights-based approaches have demonstrated the importance of proactive measures, including robust national laws to prevent recruitment abuse through not only regulation and licensing, but alongside active monitoring and inspection to protect migrant workers.

7.2.2 Illegal recruitment produced conditions for workplace exploitation

Within the global literature on migrant recruitment, the role of recruitment agencies and migrant brokers has been examined, particularly throughout Asia (Agunias, 2010; Debonneville, 2021; Farris, 2020; Lindquist et al., 2012), however, the range and role of stakeholders across the migration industry is less understood within the context of destination countries, such as Canada. My data builds on the global literature on non-state actors throughout the migration industry and adds new data on recruiting agents operating in Canada as well as the long-term effects of illegal recruitment on the economic and social integration of migrant care workers. My data demonstrates how fraudulent recruitment of migrant care workers not only endangers the safety of migrant workers, but also exacerbates their vulnerability for future workplace exploitation, both contributing to psychological trauma with immediate and long-term effects on mental health and well-being.

My research illustrated how women who paid illegal recruitment fees were far more vulnerable to being given a fraudulent job offer and employment contract by a “ghost employer” (Standing Committee on Citizenship and Immigration, 2009) who was fabricated by recruitment agents in Canada. This process known as “release upon arrival” (Faraday, 2014) effectively forced women out of their legal immigration status upon arrival in Canada. Without the employer stated on their closed work permit and who they were supposed to live with, these women were left homeless, in debt, out of work, and with few options for new employers with a positive LMIA needed for a new work permit under a caregiver program. The multitude of effects precarious legal status has on

migrant workers in Canada has been noted in the literature, including how regulatory frameworks create conditions for migrant's irregularization (Landolt & Goldring, 2012). The cumulative and compounding impacts of regulatory barriers has been shown to play a strong role in shaping the trajectory of both the precarity of migrant legal status as well as precarious work (Landolt & Goldring, 2012). My study contributes to research on the compounding and prolonged vulnerabilities migrant workers in Canada experience as a result of their precarious legal status, including limited job opportunities and predatory relationships with exploitative employers as well as immigration consultants and lawyers (Landolt & Goldring, 2012). My data confirms the long-lasting negative effects precarious legal status can have on migrant care workers, specifically with respect to their mental health, as periods of uncertainty were characterized by fear, stress, depression, and isolation.

My research also contributes to literature on care work, gender, and migration by analyzing how recruitment agents or migrant brokers operating within the Canada play an active role in facilitating access to the Canadian labour market as well as the care industry, for both migrant care workers and Canadian families who are recipients/beneficiaries of care. By exploring the pathways of migrant care workers to Canada, I have contributed to the scant research on how agents in destination countries mediate the regulatory frameworks established by the state, including the production of precarious legal status and the working conditions that shape the vulnerabilities of women. I add new data explicating the role of recruitment agents in mediating access to global labour markets (Lindquist et al., 2012; Wee et al., 2019), specifically within the Canadian context, and how this was often done through illegitimate means. Upon arrival

in Canada, unscrupulous recruitment agents forced women out of their legal immigration status producing compounding effects throughout their time in the LCP. Further, my data contributes important insights on how migrant care workers strategize their migration pathways, work, and familial obligations.

There remains a need for increased transparency and accessibility of federal and provincial information sharing about licensed recruiters and employers with positive LMIA's. Immediately connecting migrant workers with information and resources to seek support from migrant workers groups, community organizations, and labour advocates would be another needed proactive step in ensuring the safety of migrant workers. Past research (Faraday, 2014; Nakache, 2012) and the present study have both found that when the onus falls on migrant workers to report fraudulent recruitment, illegal recruitment fees, and/ or poor working conditions, they are unable to assert their labour rights. At risk of homelessness, termination, and/or retaliation from employers and/or recruiters, this research has demonstrated how the lack of proactive protections undermines migrant care workers' rights with lasting consequences for their health as well as the long-term well-being of their families.

7.2.3 Employer-tied work permits produced exploitative working and living conditions

Across international literature on migrant domestic work (Anderson, 2000; Hondagneu-Sotelo, 2001; Parrenas; 2005) and national literature on Canadian caregiver programs (Arat-Koc, 2006; Bakan & Stasiulis, 2012; Bhuyan et al., 2017; Bourgeault et al., 2010; Fudge & Parrot, 2013; Spitzer & Torres, 2008; Straehle, 2013; Tungohan et al., 2015), the themes of exploitative working conditions and poor living conditions have been

highlighted. The high dependency of migrant care workers on a single employer for both work as well as a place to live has been widely recognized in the literature as fundamentally producing the vulnerability of migrant care workers (Cedillo et al., 2019; Nakache, 2012), as well as other temporary foreign workers in Canada (Edmunds et al., 2011; Hennebry et al., 2015; Sargeant & Tucker, 2009). My study confirms these findings and add new data on how migrant care workers have strategized their work arrangements, navigated periods of being without an employer, for a range of reasons, such as being released upon arrival, a client passing away, being let go, or being replaced, as well as the impact this had on their overall well-being.

Canadian literature on migrant worker health has predominantly focused on seasonal agricultural workers and those working in sectors, such as fast food (Polanco, 2016), hospitality, construction, and meat processing (Cedillo et al., 2019; Salami et al., 2015), however, the isolation of migrant care workers further limits their supports and restricts the number of potential employers they can work for. Studies on the LCP (Bhuyan et al., 2018; Faraday, 2014; Tungohan, 2019) have noted how immigration policies and programs that produce longer periods of precarious migrant status increase the likelihood of falling out of status, forcing migrant care workers to do jobs outside of their closed work permits, and in both cases contributing to the production of their “illegality”. My study adds new data on how women navigated these periods of unemployment as well as the compounding effects of closed work permits on their vulnerability with implications on their health.

Employer-tied work permits had numerous consequences for participants, including compromising their eligibility for provincial health care coverage. The effects of their

recruitment, closed work permit, and employment contract had immediate consequences for their access to health care coverage. Time between or without an employer with a positive LMIA and a work permit for them marked periods of profound stress for women, often lasting several months. This time between work permits and new employers significantly extended their time to completion of the LCP. During this period of uncertainty, their vulnerability compounded in numerous ways, including financial hardship, homelessness, falling out of legal immigration status, and predatory relationships with employers and fraudulent immigration consultants.

7.2.4 'Implied status' extended precarity and uncertainty for migrant care workers

Within the national literature on the health and occupational safety of temporary foreign workers, immigration status as a foundational determinant of health (Gagnon et al., 2021; Salami et al., 2015) has been a dominant theme as well as the barriers to transitioning to permanent residency (PR) for low-skilled migrant workers (Nakache, 2012). My data confirms the pivotal role of immigration status on access to the health care for migrant care workers, however, it also adds important insights on how immigration procedures and bureaucratic application processing delays can also produce barriers to care. Within the Canadian immigration system, there are increasingly limited opportunities to transition to PR for migrant workers in sectors classified as low-skilled (Nakache, 2012). My examination of the transition period to PR for women who completed the LCP contributes new data on how migrant care workers continue to be excluded from full rights and entitlement to health and social services. My data also outlines how this

continued exclusion can have significant impacts on the mental health and well-being of principal applicants as well as their families.

After years of working to complete the LCP, women waited anywhere from six months to more than ten years for a decision on their family's PR application. During this period of uncertainty, the legal immigration status of migrant care workers was known as "implied status". Few studies on the LCP examine the transition period to PR and the long-term effects of implied status over extended periods of time. This period of implied status extended by application processing backlogs is described by Bhuyan et al. (2018) as a type of symbolic violence for caregivers putting them in a liminal state that exacerbates the trauma of prolonged family separation. Findings from my study contribute new data to better understand the full trajectory of women's lives, including the time following their completion of the program and their experiences of transitioning to PR. These insights highlight how these transition periods and having implied status for a prolonged time are among the most vulnerable times for women who completed the LCP. Migrant care workers and their families faced lengthy and costly challenges trying to navigate complex government systems and procedures, becoming especially vulnerable to predatory immigration consultants and lawyers. This period of implied status left women in limbo with uncertain access to health care and social services, often left to the interpretation and discretion of frontline administrative support service staff.

As families anticipated the transition to PR, the period of implied status added years of profound stress, anxiety, and continued separation. At any point during these times, the immigration status of workers can be compromised, along with their right to work and access services, such as health care. Indeed, some women I spoke with were refused

health care coverage as well as health care services during this period of Implied Status due to expired health cards and open work permits that needed to be continually renewed. Due to the COVID-19 pandemic, processing backlogs were exacerbated, as migrant care workers reported unstable housing, difficulty getting sick leave, and accessing health services and mental health supports. Those that faced difficulty with their family's application were also left vulnerable to being taken advantage of by unlicensed immigration consultants that charged exorbitant legal fees.

7.2.5 Constrained familial relationships

Within global literature on migrant care work, there has been increased attention on the families of migrant care workers, including the dominant themes of the obligation to financially support family left behind (Kelly, 2017; Vahabi & Wong, 2017) and strategies to maintain transnational relationships with loved ones back home (Cuban, 2014; Fresnoza-Flot, 2009; Kilkey & Merla, 2014; Peng & Wong, 2013). In her decolonial analysis of migrant care work in Canada, Tungohan (2019) draws attention to how these paradoxical policies lead to experiences of structural and everyday violence that affects and becomes imprinted on the 'bodies and minds' (p. 239) of different groups of migrant domestic workers. The cumulative time some women had been apart from their families between serial care work contracts around the world varied widely from six months to over thirteen years, giving rise to mixed feelings of wanting to maintain connection despite often feeling forgotten. Bhuyan et al. (2018) also noted that migrant care workers in Canada hid their problems from family and friends back home from fear of being the subject of gossip and scrutiny in their communities back home. My study confirms this

and adds new data on the complexity of how these transnational relationships strongly influence women's mental health.

Increasingly, migration scholars (Hankivsky, 2014; Sargeant and Tucker, 2009; Tungohan et al., 2019) have called attention to the need to contextualize the multiple levels of power inequities that compound the precarity of migrant well-being and work. Sargeant and Tucker (2009) have outlined three layers of vulnerability in the occupational health and safety of migrant workers. Along with migration factors (e.g., conditions of recruitment and immigration programs) and receiving country conditions (e.g., access to regulating protection, problems of social exclusion and social isolation, and occupational risks and hazards), characteristics of migrant workers related to their country of origin were important layers that exacerbated occupational health and safety risks experienced by migrant workers. My study confirms how a sense of obligation to provide for their loved ones back home and the expectation of sponsoring their children and spouses grounded women's decision-making. Women's perceived responsibilities to their families strongly dictated the type of work they would accept, employers and clients they would tolerate, how they managed their money (e.g., living arrangements and food) to meet their own needs, and how they managed their own health and well-being.

Previous literature has also noted the ambivalent role of family as a social support for migrant care workers in Canada (Bhuyan et al., 2018; Vahabi & Wong, 2017). My research confirms this and also contributes new data on the mixed feelings women had about their constrained relationships with their families and their obligations to them. After working in previous countries for up to thirteen years and then in Canada, some participants shared how they felt forgotten, especially by their spouses. They also shared

how this led to persistent feelings of sadness, burnout, and fatigue, characteristic of depression. Despite feeling depressed, many of the women also shared that they never told their families back home how they were really feeling or about any of the issues they faced in Canada. Their rationale for not telling their families about their problems was often framed as a pragmatic consideration because they felt their families would not be able to help them anyways.

My data further contrasts the feelings women had about the dependence of their families on their remittances and how this shaped their relationships with their children, spouses, parents, siblings, nieces, and nephews. Some of the participants described financially supporting their families as their primary role and purpose in life. Along with this, they shared feelings of guilt and contrasted trading time they could never get back with their children for opportunities (e.g., private school) that their children would otherwise not have. The women shared different strategies they used to try to maintain an emotional connection and relationship with their children, such as video calling, sending gifts, along with remittances, and regularly calling to check in about their schooling and well-being.

Findings from my study also suggest the need for an intersectional approach (Hankivsky, 2014; Lightman et al., 2021) to examine transnational care work configurations and global care chains (GCCs) in order to better understand how migrant care workers exercise their agency when navigating their transnational social locations. While Arlie Hochschild's theorization of the transfer of care in GCCs assumed women in the Global South bore the brunt of displaced care (2000), the women I spoke with supported a range of family formations, care dynamics, and household demands. Applying an intersectional lens to GCCs has been critical to nuancing how migrant care workers manage their

multiple care responsibilities both in Canada and in the Philippines as well as exploring the varied transnational family configurations, beyond traditional understandings of family separation and displaced care. As Tungohan (2019) expanded on family arrangements of Filipina migrant care workers using queer phenomenology, she noted how many of these arrangements transcend heterosexual and GCC models, which often assume that female relatives do care work while migrant care workers' spouses work themselves. Throughout this study, this assumption has also been challenged as some women were single or separated, however, they continued to support alternative family structures, which has received less attention throughout the literature on migrant care work, transnational families, and migrant family separation.

7.3 Continuing changes to migrant care work programs in Canada

All of the women I spoke with came to Canada through the LCP, which ended in November 2014. Since then, there have been three iterations of migrant care worker programs: Caring for People with High Medical Needs Program and the Caring for Children Program until June 2019; from June to October 2019 the Interim Pathway for Caregivers; and currently the Home Child Care Provider Pilot and Home Support Worker Pilot launched in June 2019 for five years. The history of foreign domestic work in Canada through racialized temporary labour schemes was established before the LCP as well, through the Caribbean Domestic Scheme that began in the 1950s, followed by the Foreign Domestic Movement program in 1981, until the LCP in 1992 (Hsuing & Nichol, 2010). The introduction of occupation-specific work permits with the current Home Child Care Provider Pilot and Home Support Worker Pilot was a welcomed change, however,

community advocates have called attention to the restrictive requirements to qualify for the program (Panlaqui & Rajasekar, 2021). Despite the longstanding and continued need for migrant care workers in Canada, the inherent precarity of the temporary foreign worker programs endures.

The COVID-19 pandemic has exacerbated many of the poor working conditions experienced by migrant care workers as they have reported increased workloads and hours with employers and children who were working from home (Caregivers' Action Centre, 2020). Working within employers' homes without permanent resident status continues to limit the extent to which migrant care workers can assert their rights by still fostering dependency on employers to complete enough work hours to become eligible for PR. Due to the reduced capacity by IRCC to process applications for PR that were submitted during the COVID-19 pandemic, there are also now multiple year processing delays with a backlog of 9100 (Keung, 2021). This prolonged uncertainty even after completing the LCP was a situation similar to the backlog experienced in 2017 by my study participants during which they and their families faced years of waiting anxiously for their permanent status approval and to be reunited with each other.

Even with a pathway to PR through a temporary foreign worker program, migrant workers are left vulnerable to poor working conditions and exploitative employers in order to complete the program. They and their families must then navigate the application process for PR within the context of unpredictable government processing times. This transition period between completing the care work requirements and awaiting approval of PR applications known as "Implied Status" is a grey area that can be fraught with legal and bureaucratic complications because of the variable interpretation by frontline service

staff. Lasting anywhere from six months to several years, this period is not only emotionally distressing for families that have already been separated for years, but also financially burdensome because of the need to re-submit paperwork (e.g., travel to and cost of medical examinations) that expires. The temporariness inherent to Canadian migrant care worker programs continues to produce periods of profound uncertainty both throughout the completion of programs and the time to process PR applications.

Some changes introduced with the Home Child Care Provider Pilot and Home Support Worker Pilot in 2019 were welcomed, such as the occupation-specific work permits, and open work permits or study permits for family members. The temporary nature of the program, however, maintains the vulnerability of migrant care workers and their families to unscrupulous immigration recruiters, abusive employers, immigration consultants, and government processing times throughout the stages of applying to a temporary foreign worker program, working in the program, and transitioning to PR. Importantly, these changes were also introduced with heightened education and language requirements, specifically the year of post-secondary education and English at a level 5. Reports from the *Toronto Star* found that over 18 months, despite 1055 new work permit applications, there were no new work permits issued under the program, due to these restrictive work, education, and language requirements (Panlaqui & Rajasekar, 2021).

7.3.1 Preventive protections against illegal recruitment

This thesis examined the conditions of migration and work for migrant care workers in the former LCP. It raises important questions about the enduring need for care workers in Canada and how that work is valued vis-a-vis the rights of temporary foreign workers. Proactive protection of migrant workers across both federal and provincial regulations

could prevent the exploitation of prospective migrant care workers as well as other groups of temporary foreign workers. Registration of recruitment agencies and prosecution for illegal recruitment fees could protect prospective applicants around the world from fraudulent recruiters. Meeting international standards for ethical labour recruitment is the responsibility of Canadian governments whose residents benefit the most from the labour of migrant workers. Without such regulations in place, prospective temporary foreign workers and international migrant care workers interested in working in Canada are preyed on by unscrupulous recruitment agents operating within Canada. My research has demonstrated how illegal recruitment fees collected by illegal recruitment agents exponentially endangers migrant workers and their families prior to immigration, upon arrival, and throughout settlement.

Protections for temporary foreign workers, including migrant care workers, are significantly more robust in Nova Scotia, Manitoba, and Saskatchewan than in Ontario. Under the *Employment Protection for Foreign Nationals Act* (EPFNA), recruitment fees in Ontario are banned, however substantive changes are still needed by the province to actualize meaningful protections for migrant workers. For decades migrant workers (Migrant Workers Alliance for Change, 2020), legal experts (Faraday, 2014), service providers (The Neighbourhood Organization, 2021), and advocates (Caregivers' Action Centre, 2020) have been calling for:

- Requiring compulsory licensing of all recruiters in Ontario
- Requiring compulsory registration of all migrant worker employers in Ontario
- Holding recruiters and employers jointly financially liable for violating labour protections

Further, any regulations currently in place need to be enforced through implementing mechanisms for reporting violations and investigation of these claims. Upon arrival as well as during pre-departure seminars, information for supports needs to be provided in order to connect migrant workers with migrant work groups, labour advocates, and community organizations that can assist with emergency shelter and housing, if needed upon landing.

7.4 Reflections as an insider-outsider researcher

Canada's unique promise for permanent residency is the allure of its temporary migrant work programs, despite the increasingly limited opportunities and restrictive requirements to transition to PR for low-skilled migrant workers. My identity and experiences as a second generation Filipina-Canadian are influenced by previous waves of Canadian immigration programs and the Philippine labour export policy of the 1970s. After being recruited by a Canadian employer in Manila, Philippines to work as a housekeeper in a hotel in Regina, Saskatchewan, my mother arrived in Canada in 1978 with her two female cousins, leaving behind her two parents and five siblings. During this previous wave of Canadian immigration, my mother was afforded the opportunity to sponsor her family, including her parents and siblings. My upbringing as a Filipina-Canadian is against this backdrop of familial support, raised not only by my parents, but surrounded by my grandparents and extended family. My understanding of Filipino culture and identity is grounded in this history of migration, transnational relationships, and gendered commodification.

As an insider-outsider researcher, my family's experiences contrasted with those of the women I spoke with. Many of them were highly educated with training in diverse fields,

such as nursing, physical therapy, teaching, business, or engineering, that they worked in prior to leaving the Philippines. While some worked as health professionals overseas, their work experience in Canada was marked by the experience of deskilling through the LCP. Some of the women's experiences aligned with those of my family, and my parents also went through painful deskilling processes, which had a lasting psychological toll on them, which they spoke about throughout my childhood. While my mother was an accountant in the Philippines before leaving to work as a hotel housekeeper in Canada, my father was a practicing medical doctor in the Philippines before joining my mother in Canada during a time when his foreign credentials would not be recognized. The experience of deskilling through low skill immigration programs was a common defining feature of the women spoke with as well as my family, it was not an experience I have had to personally contend with, as a Canadian-born and educated researcher.

Language was another important marker of my difference since my verbal communication skills in Tagalog are limited. In spite of this, my gender, age, and general understanding of the language and cultural traditions often helped to build rapport with community members. I was often asked if I knew of certain traditions, customs, phrases, or words, and upon confirming that I understood, I was met with sighs of relief that no explanation would be needed. While the women I spoke with varied in age, many also shared that I reminded them of a niece, relative, or friend. At the drop-in centre, during community gatherings, and across meetings in the Philippines, when food was customarily shared, hosts also took comfort knowing I was familiar with the food they had to offer. Sharing meals was an important cultural activity that also acted as an opportunity for casual exchange for attendees to learn more about one another, build

connections, and maintain relationships. During these informal conversations, women were able to share stories about their families, employers, and friends in the community as well as exchange advice about job opportunities, where to get help with paperwork, and how to manage relationships with their clients and employers.

This research has emphasized the importance and power of fostering community connection and support, in the absence of one's family and home community. In times of distress, however, those seeking urgent help are often more vulnerable to being taken advantage of before they are able to establish trusted relationships with friends and neighbourhood supports. Community connection was formed between migrant care workers as a reprieve from daily work and found in parks, church basements, community centers, and online through social media platforms. These were spaces for mental health support, reprieve, and connection with friends. These shared safe spaces that were provided were invaluable to their well-being as well as learning about their rights and services available. The migrant advocates and support providers I spoke to and worked with were key sources of trusted, reliable information at no cost. Too often, they would only be put in touch with service providers after being taken advantage of by immigration recruiters and/or consultants or when they were already experiencing advanced sickness and in need of urgent medical help.

As a Filipina-Canadian visiting doctoral student researcher and doctoral fellow with Ateneo de Manila University in the Philippines, I was granted access to researchers, professors, civil society organizations, government representatives, and international organizations through invitations to meetings, presentations, workshops, consultations, and conferences. As a Canadian-born and educated Filipina in the Philippines, I was also

met with surprise that I would be interested in studying migration and health. Along with surprise, at times there would also be an air of dismissal, perhaps both at the subject matter of Canadian migration as well as my personal identity as Canadian likely because of the security and privilege I was born with. Canada was still thought of as offering one of the best qualities of life in the world and one of the only countries offering “free healthcare”. Frontline service providers and advocates working directly with migrant workers both in Canada and in the Philippines, however, were more often skeptical of researchers. My identity as a Filipino-Canadian as well as my experiences working with grassroots community organizers helped to open up discussions. On the other hand, as I met women working in the LCP in the GTA and explained the study, I was met with surprise that I would be interested in learning about their experiences and hearing their stories.

7.5 Conclusion

The exponential increase of temporary residents, including temporary foreign workers and international students, to Canada is fundamentally changing the nature of the Canadian immigration system and the notion of who gets to stay in Canada. Despite their temporary work permit and legal immigration status, migrant care workers fill longstanding labour shortages, contributing to the broader Canadian health care system and providing essential care to children, aging Canadians, and Canadians with high medical needs. The increasing stratification of immigration programs and two-step pathways to PR presents important considerations about the complexity of navigating Canadian immigration programs. Fraught with increasing language, educational, and work experience requirements, migrants are increasingly turning to migrant brokers and

recruitment agents to navigate the growing complexity of the Canadian immigration system, including application processes. My study has highlighted how the global migration industry, including recruiting agents operating in Canada, play an active role in shaping the long-term trajectories of migrant workers.

The commodification of women's labour begins long before they start working, as the Philippines national labour export policy, class, and gender drives the structure of the Philippines economy as it competes with global economic forces. Embroiled in overlapping migrant labour systems and global care economies, migrant care workers and their families bear the burden of the intertwined global dependency on migrant labour systems, as the cycle of precarity deepens and continues. The complexity of immigration applications, the extensive requirements for eligibility, combined with the lack of support to find appropriate employers gives rise to unregulated private actors who effectively facilitate immigration to Canada. Without protections abroad or in Canada, migrant care workers are taken advantage of by unscrupulous private recruiters who charge illegal recruitment fees for fraudulent employment contracts. This both endangers the safety of women immediately upon arrival in Canada, forces their illegal immigration status, limits job options as they seek new employers under the LCP, and threatens the limited time they have to complete the LCP to qualify for PR.

Migrant care workers protect and support the health of the most vulnerable Canadians, contributing to the broader health system from which they are so often excluded. By providing this care labour, these migrant women provide Canadian families a sense of safety and security knowing their loved ones are being cared for in their own homes. Yet, the ability to assert their own labour rights, right to health care, and right to be with their

families are denied. As Canada continues to grapple with an ageing population and intensifying care crisis, it is imperative we value the labour of migrant care workers by ensuring their safety and well-being as well as the opportunity to be joined with their own families. As receiving countries benefit from the care provided by migrant care workers and countries of origin benefit from the remittances they send back home, protection of migrant care workers through multi-level policy coordination ensuring ethical recruitment and labour practices is vital not only for their safety, but also the well-being of the families that also rely on them.

References

- Agunias, D. R. (2010). *Migration's Middlemen: Regulating recruitment agencies in the Philippines-United Arab Emirates Corridor. Policy*. Washington, DC.
- Anderson, B. (2000). *Doing the dirty work?: The global politics of domestic labour*. London; New York: Zed Books.
- Andrees, B., Nasri, A., & Swiniarski, P. (2015). *Regulating labour recruitment to prevent human trafficking and to foster fair migration: Models, challenges and opportunities*. International Labour Organization. Retrieved from http://www.ilo.org/global/publications/working-papers/WCMS_377813/lang--en/index.htm
- Arat-Koc, S. (2006). Whose social reproduction? Transnational motherhood and challenges to feminist political economy. In Luxton, M., & Bezanson, K. (Eds.). *Social reproduction: Feminist political economy challenges neo-liberalism*. Montreal: McGill-Queen's University Press.
- Asselin, M. E. (2003). Insider Research: issues to consider when doing qualitative research in your own setting. *Journal for Nurses in Staff Development (JNSD)*, 19(2), 99–103.
- Atanackovic, J., & Bourgeault, I. L. (2014). *Economic and Social Integration of Immigrant Live-in Caregivers in Canada. IRPP Study (Vol. 46)*. Retrieved from <https://irpp.org/fr/research-studies/economic-and-social-integration-of-immigrant-live-in-caregivers-in-canada/>
- Bakan, A.B., & Stasiulis, D. (1996). Structural adjustment, citizenship, and foreign domestic labour: The Canadian Case. In Bakker, I. C. (Ed.). *Rethinking restructuring: Gender and change in Canada*. Toronto: University of Toronto Press.
- Banerjee, R., Kelly, P., Tungohan, E., GABRIELA-Ontario, Migrante-Canada, & Community Alliance for Social Justice. (2017). *Assessing the Changes to Canada's*

- Live-In Caregiver Program : Improving Security or Deepening Precariousness? A Pathways to Prosperity Project*. Retrieved from <http://p2pcanada.ca/wp-content/blogs.dir/1/files/2017/12/Assessing-the-Changes-to-Canadas-Live-In-Caregiver-Program.pdf%0Ahttp://deslibris.ca.ezproxy.lib.ucalgary.ca/ID/10094882>
- Battistella, G., & Asis, M. (2011). *Protecting Filipino Transnational Domestic Workers: Government Regulations and Their Outcomes*. *Philippine Institute of Development Studies*. Retrieved from <http://www.pids.gov.ph>
- Bhuyan, R., Valmadrid, L., Panlaqui, E. L., Pendon, N. L., & Juan, P. (2018). Responding to the Structural Violence of Migrant Domestic Work: Insights from Participatory Action Research with Migrant Caregivers in Canada. *Journal of Family Violence*, 33(8), 613–627. <https://doi.org/10.1007/s10896-018-9988-x>
- Bobadilla, A., Orchard, T., Magalhães, L., & Fitzsimmons, D. (2017). Ontario Healthcare Coverage Eligibility Among New Permanent Residents: A Scoping Review. *Journal of Immigrant and Refugee Studies*, 15(4), 384–405. <https://doi.org/10.1080/15562948.2016.1214993>
- Bourgeault, I. L., Parpia, R., & Atanackovic, J. (2010). Canada's Live-In Caregiver Program: Is it an Answer to the Growing Demand for Elderly Care? . *Journal of Population Ageing* . Dordrecht : Springer Netherlands . <http://doi.org/10.1007/s12062-010-9032-2>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Caregivers' Action Centre, The Vancouver Committee for Domestic Workers and Caregivers Rights, Caregiver Connections, E. and S. O., & The Migrant Workers Alliance for Change. (2020). *Behind closed doors*. Retrieved from www.MigrantRights.ca/BehindClosedDoors
- Carling, J., Erdal, M. B., & Ezzati, R. (2014). Beyond the Insider-Outsider Divide in Migration Research . *Migration Studies* . <http://doi.org/10.1093/migration/mnt022>

- Carlos, J. K., & Wilson, K. (2018). Migration among temporary foreign workers : Examining health and access to health care among Filipina live-in caregivers. *Social Science & Medicine*, 209(May), 117–124.
<https://doi.org/10.1016/j.socscimed.2018.05.045>
- Carspecken, P. F. (1996). *Critical ethnography in educational research: a theoretical and practical guide*. New York : Routledge.
- Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M. E. D. T., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health*, 36, 375–392. <https://doi.org/10.1146/annurev-publhealth-032013-182419>
- Cedillo, L., Lippel, K., & Nakache, D. (2019). Factors Influencing the Health and Safety of Temporary Foreign Workers in Skilled and Low-Skilled Occupations in Canada. *NEW SOLUTIONS: A Journal of Environmental and Occupational Health Policy*, 0(0).
- Chen, Y. Y. B. (2017). The future of precarious status migrants’ right to health care in Canada. *Alberta Law Review*, 54(3), 649–663.
- Cook, K. E. (2005). *Using Critical Ethnography to Explore Issues in Health Promotion*. *Qualitative Health Research* . Sage CA: Thousand Oaks, CA: Sage Publications .
<http://doi.org/10.1177/1049732304267751>
- Cristaldi, F., & Darden, J. (2011). The Impact of Immigration Policies on Transnational Filipino Immigrant Women: A Comparison of Their Social and Spatial Incorporation in Rome and Toronto. *Journal of Urban History*, 37(5), 694–709.
<https://doi.org/10.1177/0096144211407743>
- Cuban, S. (2014). Transnational families, ICTs and mobile learning. *International Journal of Lifelong Education*, 33(6), 737–754. Retrieved from
<http://www.scopus.com/inward/record.url?eid=2-s2.0-84911427177&partnerID=40&md5=2dd1087641fd82ebc204c6797074ce50>

- Debonneville, J. (2021). An organizational approach to the Philippine migration industry: recruiting, matching and tailoring migrant domestic workers. *Comparative Migration Studies*, 9(1). <https://doi.org/10.1186/s40878-020-00220-2>
- De Leon, C. (2009). Post-Reunification Reconciliation among PINAY Domestic Workers and Adult Daughters in Canada. *Canadian Woman Studies*, 27(1). Retrieved from <https://cws.journals.yorku.ca/index.php/cws/article/view/24223>
- Deloitte. (2021). *Canada's elder care crisis: addressing the double demand*. Retrieved from <https://www.cma.ca/sites/default/files/pdf/health-advocacy/activity/CMA-LTC-Deloitte-Report-EN.pdf>
- DeSantis, Lydia; Ugarriza, D. N. (2000). The concept of theme as used in qualitative nursing research. *Western Journal of Nursing Research*, 22(3), 351–372.
- Dickinson, D. (2016). *Migrant worker recruitment costs: Philippines*.
- Drolet, N. (2016). An Overview of Canada's New Caregiver Program: A Shift From Permanence to Precariousness. *Immigration & Citizenship*, (6), 1–4. ISSN 0843-7564
- Edmunds, K., Berman, H., Basok, T., Ford-Gilboe, M., Forchuk, C. (2011). The Health of Women Temporary Agricultural Workers in Canada : A Critical Review of the Literature. *Canadian Journal of Nursing Research*, 43(4), 68–91.
- Erickson, F. (2005). A history of qualitative inquiry in social and educational research. In N.K. Denzin & Y.S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 43-60). Los Angeles: SAGE.
- Faraday, F. (2014). *Profiting from the Precarious: How Recruitment Practices Exploit Migrant Workers*. Metcalf Foundation. Retrieved from <https://metcalffoundation.com/publication/profitting-from-the-precarious-how-recruitment-practices-exploit-migrant-workers/>

- Faraday, F. (2016). *Canada's Choice: Decent work or entrenched exploitation for Canada's migrant workers?*. Retrieved from <https://metcalfoundation.com/publication/canadas-choice/>
- Farris, S. R. (2020). The business of care: Private placement agencies and female migrant workers in London. *Gender, Work & Organization*, 27, 1450–1467. <https://doi.org/10.1111/gwao.12520>
- Foley, D. & Valenzuela, A. (2005). Critical ethnography: The politics of collaboration. In N.K. Denzin & Y.S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 217-234). Los Angeles: SAGE.
- Fresnoza-Flot, A. (2009). Migration status and transnational mothering: The case of Filipino migrants in France. *Global Networks*, 9(2), 252–270. Retrieved from <http://www.scopus.com/inward/record.url?eid=2-s2.0-61849163908&partnerID=40&md5=68e469b89eca0e415ce62b9530a8b2fc>
- Fudge, J. (2011). Global care chains, employment agencies, and the conundrum of jurisdiction: Decent work for domestic workers in Canada. *Canadian Journal of Women and the Law/Revue Femmes Et Droit*, 23(1), 235-264. doi:10.3138/cjwl.23.1.235
- Fudge, J., & Parrott, D. (2013). Placing Filipino caregivers in Canadian homes: Regulating transnational employment agencies in British Columbia. *Temporary Work, Agencies and Unfree Labour: Insecurity in the New World of Work*.
- Gagnon, M., Kansal, N., Goel, R., & Gastaldo, D. (2021). Immigration Status as the Foundational Determinant of Health for People Without Status in Canada: A Scoping Review. *Journal of Immigrant and Minority Health*, 24(4), 1029–1044. <https://doi.org/10.1007/s10903-021-01273-w>
- GATES. (2014). *From "Migrant" to "Citizen": GATES Preliminary Analysis*.

- Goldring, L., Berinstein, C., & Bernhard, J. K. (2009). Institutionalizing precarious migratory status in Canada. *Citizenship Studies*, 13(3), 239–265.
<https://doi.org/10.1080/13621020902850643>
- Hankivsky, O. (2014). Rethinking care ethics: On the promise and potential of an intersectional analysis. *American Political Science Review*, 108(2), 252–264.
 Retrieved from <http://www.scopus.com/inward/record.url?eid=2-s2.0-84902384149&partnerID=40&md5=2134c0629d5183500758af0784d2b1df>
- Hennebry, J., McLaughlin, J., & Preibisch, K. (2015). Out of the Loop: (In)access to Health Care for Migrant Workers in Canada. *Journal of International Migration and Integration*. <https://doi.org/10.1007/s12134-015-0417-1>
- Hochschild, A.R. (2000). “Global Care Chains and Emotional Surplus Value.” In W. Hutton, and A. Giddens (Eds.), *On the Edge: Living with Global Capitalism*. London: Jonathan Cape.
- Hondagneu-Sotelo, P. (2001). *Doméstica: immigrant workers cleaning and caring in the shadows of affluence*. University of California Press.
- Hsiung, P.C., & Nichol, K. (2010). Policies on and Experiences of Foreign Domestic Workers in Canada. *Sociology Compass*, 4(9), 766–778.
<https://doi.org/10.1111/j.1751-9020.2010.00320.x>
- Kastner, M., Tricco, A. C., Soobiah, C., Lillie, E., Perrier, L., Horsley, T., Welch, V., Cogo, E., Antony, J., & Straus, S. E. (2012). What is the most appropriate knowledge synthesis method to conduct a review? Protocol for a scoping review. *BMC Medical Research Methodology*, 12, 1–10. <https://doi.org/10.1186/1471-2288-12-114>
- Kelly, P., Park, S., de leon, C., & Priest, J. (2011). *Profile of live-in caregiver immigrants to Canada, 1993-2009*. Toronto Immigrant Employment Data Initiative. Toronto, ON.

- Kelly, P. (2014). *Understanding Intergenerational Social Mobility*. Retrieved from <https://irpp.org/fr/research-studies/understanding-intergenerational-social-mobility/%0Ahttps://irpp.org/wp-content/uploads/assets/research/diversity-immigration-and-integration/filipino-youth/kelly-feb-2014.pdf>
- Kelly, P. F. (2015). Transnationalism, emotion and second-generation social mobility in the Filipino-Canadian diaspora. *Singapore Journal of Tropical Geography*, 36(3), 280–299. <https://doi.org/10.1111/sjtg.12115>
- Kelly, P. (2017). Migration, development and remittances. In A. McGregor, L. Law, & F. Miller (Eds.), *Routledge Handbook of Southeast Asian Development* (1st Edition, pp. 198–210). London: Routledge. <https://doi.org/10.4324/9781315726106-18>
- Keung, N. (2008). Nanny battling terminal cancer gets reprieve. *Toronto Star*. https://www.thestar.com/news/gta/2008/07/19/nanny_battling_terminal_cancer_gets_reprieve.html
- Keung, N. (2021). Canada moves to sort out caregivers ' immigration backlog and processing. *Toronto Star*.
- Kilkey, M., & Merla, L. (2014). Situating transnational families' care-giving arrangements: The role of institutional contexts. *Global Networks*, 14(2), 210–229. Retrieved from <http://www.scopus.com/inward/record.url?eid=2-s2.0-84895881335&partnerID=40&md5=ec5efad5b0b6e248a0b00141f98ef2d9>
- Kincheloe, J., McLaren, P., & Steinberg, S. (2011). Critical pedagogy, and qualitative research: Moving to the bricolage. In N.K. Denzin & Y.S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 163-178). Los Angeles: SAGE.
- Kofman, E. (2012). Rethinking care through social reproduction: Articulating circuits of migration. *Social Politics*, 19(1), 142-162.
- Lacsamana, A.E. (2009). Identities, nation and imperialism: Confronting empire in Filipina American feminist thought. In Lindio-McGovern & Wallimann, I. Farnham

(Eds.), *Globalization and third world women: Exploitation, coping and resistance*, (pp. 65-80).

- Landolt, P., & Goldring, L. (2012). The social production of non-citizenship: The consequences of intersecting trajectories of precarious legal status and precarious work. In *Producing and Negotiating Non-Citizenship: Precarious Legal Status in Canada* (pp. 154–174). <https://doi.org/10.3138/9781442663862-012>
- Lightman, N., Banerjee, R., Tungohan, E., de Leon, C., & Kelly, P. (2022). An intersectional pathway penalty: Filipina immigrant women inside and outside Canada's Live-In Caregiver Program. *International Migration*, 60(2), 29–48. <https://doi.org/10.1111/imig.12851>
- Lindquist, J., Xiang, B., & Yeoh, B. S. A. (2012). Opening the Black Box of Migration: Brokers, the Organization of Transnational Mobility and the Changing Political Economy in Asia. *Pacific Affairs*, 85(1), 2,7-19.
- Lutz, H., & Palenga-Möllenbeck, E. (2012). Care Workers, Care Drain, and Care Chains: Reflections on Care, Migration, and Citizenship. *Social Politics*, 19(1), 15–37. <http://doi.org/10.1093/sp/jxr026>
- Magalhaes, L., Carrasco, C., & Gastaldo, D. (2010). Undocumented Migrants in Canada: A Scope Literature Review on Health, Access to Services, and Working Conditions. *Journal of Immigrant and Minority Health*, 12, 132–151. <https://doi.org/10.1007/s10903-009-9280-5>
- Nakache, D. (2012). The Canadian temporary foreign worker program: Regulations, practices, and protection gaps. In P. Goldring, L., Landolt (Ed.), *Producing and Negotiating Non-Citizenship: Precarious Legal Status in Canada* (pp. 71–96). University of Toronto Press. <https://doi.org/10.3138/9781442663862-008>
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, 16(1), 1–13. <https://doi.org/10.1177/1609406917733847>

- Nowicka, M., & Ryan, L. (2015). Beyond insiders and outsiders in migration research: Rejecting a priori commonalities. Introduction to the FQS thematic section on “Researcher, migrant, woman: Methodological implications of multiple positionalities in migration studies.” *Forum: Qualitative Social Research*, 16(2). ISSN 1438-5627
- Jones, H. & Chhim, C. (2022). *Nearly All Canadians 45+ Years Want to Age at Home, But Only 1 in 10 (12%) Say They Can Afford the Cost of a Personal Support Worker*. Ipsos. https://www.ipsos.com/sites/default/files/ct/news/documents/2022-05/PSW_Day_2022-Factum-2022-05-19-v1.pdf
- Oishi, N. (2005). *Women in motion: Globalization, state policies, and labor migration in Asia*. Stanford, Calif.: Stanford University Press.
- Ontario Safety Association for Community & Healthcare. (2003). *Health & Safety in the Home Care Environment Health and Safety in the*. Toronto.
- Ontario. (2019). Workplace violence prevention in health care : A guide to the law for hospitals , long-term care homes and home care. Retrieved from <https://www.ontario.ca/page/workplace-violence-prevention-health-care-guide-law-hospitals-long-term-care-homes-and-home-care>
- Oxman-Martinez, J., Hanley, J., Lach, L., Khanlou, N., Weerasinghe, S., & Agnew, V. (2005). Intersection of Canadian Policy Parameters Affecting Women with Precarious Immigration Status: A Baseline for Understanding Barriers to Health. *Journal of Immigrant and Minority Health*, 7(4), 247–258. <https://doi.org/10.1007/s10903-005-5122-2>
- Parreñas. (2005). *Children of global migration : transnational families and gendered woes*. Stanford University Press.
- Parreñas, R. S. (2008). *The force of domesticity: Filipina migrants and globalization. Nation of newcomers*. New York: New York University Press.

- Panlaqui, E., & Rajesekar, J. (2021). TNO - The Neighbourhood Organization. Toronto, ON, Canada. Retrieved from <https://www.ourcommons.ca/Content/Committee/432/CIMM/Brief/BR11306033/br-external/TheNeighbourhoodOrganization-e.pdf>
- Paul, A. M. (2015). Capital and mobility in the stepwise international migrations of Filipino migrant domestic workers. *Migration Studies*, 3(3), 438–459. <https://doi.org/10.1093/migration/mnv014>
- Paul, A. M. (2017). *Multinational Maids: Stepwise migration in a global labor market*. *Multinational Maids: Stepwise Migration in a Global Labor Market*. Cambridge, U.K. ; New York, NY: Cambridge University Press. <https://doi.org/10.1017/9781108120357>
- Peng, I. (2017). *Transnational Migration of Domestic and Care Workers in Asia Pacific*. *Global Action Programme on Migrant Domestic Workers and their Families*. Geneva. Retrieved from http://www.ilo.org/global/topics/labour-migration/publications/WCMS_547228/lang--en/index.htm
- Peng, Y., & Wong, O. M. H. (2013). Diversified Transnational Mothering via Telecommunication: Intensive, Collaborative, and Passive. *Gender and Society*, 27(4), 491–513. <https://doi.org/10.1177/0891243212473197>
- Peralta-Catipon, T. (2009). Statue square as a liminal sphere: Transforming space and place in migrant adaptation. *Journal of Occupational Science*, 16(1), 32–37. <https://doi.org/10.1080/14427591.2009.9686639>
- Pingol, A. (2001). *Remaking Masculinities: Identity, Power, and Gender Dynamics in Families with Migrant Wives and Househusbands*. UP Center for Women's Studies. Manila, PH.
- Pluye, P., Hong, Q. N., Bush, P. L., & Vedel, I. (2016). Opening-up the definition of systematic literature review: The plurality of worldviews, methodologies and

- methods for reviews and syntheses. *Journal of Clinical Epidemiology*, 73, 2–5.
<https://doi.org/10.1016/j.jclinepi.2015.08.033>
- Polanco, G. (2016). Consent behind the counter: aspiring citizens and labour control under precarious (im)migration schemes. *Third World Quarterly*, 37(8), 1332–1350.
<https://doi.org/10.1080/01436597.2015.1129892>
- Pratt, G. (2004). *Working feminism*. Philadelphia: Temple University Press.
- Pratt, G. (2012) *Families Apart: Migrant Mothers and the Conflicts of Labor and Love*. University of Minnesota Press, Minneapolis, MN.
- Salami, B., Meharali, S., & Salami, A. (2015). The health of temporary foreign workers in Canada: A scoping review. *Canadian Journal of Public Health*, 106(8), e546–e554. <https://doi.org/10.17269/CJPH.106.5182>
- Sargeant, M., & Tucker, E. (2009). Layers of Vulnerability in Occupational Safety and Health for Migrant Workers: Case Studies from Canada And The UK. *Comparative Research in Law and Political Economy*, 5(2), 51–73.
<https://doi.org/10.1080/14774003.2009.11667734>
- Sarti, R. (2014). Historians, Social Scientists, Servants, and Domestic Workers: Fifty Years of Research on Domestic and Care Work. *International Review of Social History*, 59(02), 279–314. <http://doi.org/10.1017/S0020859014000169>
- Sassen, S. (1998). *Globalization and its discontents*. New York: New York Press.
- Scheil-Adlung X. (2015). *Long-term care protection for older persons: a review of coverage deficits in 46 countries*. Extension of Social Security, Working Paper 50. Geneva: International Labour Organization.
- Spitzer, D., Neufeld, A., Harrison, M., Hughes, K., & Stewart, M. (2003). Caregiving In Transnational Context. *Gender & Society*, 17(2), 267–286.
<http://doi.org/10.1177/0891243202250832>

- Spitzer, D., & Torres, S. (2008). *Gender-based barriers to settlement and integration for live-in-caregivers: A review of literature*. CERIS Working Paper No. 71. Toronto, ON.
- Spitzer, D. L., Torres, S., Zwi, A. B., Khalema, E. N., & Palaganas, E. (2019). Towards inclusive migrant healthcare. *The BMJ*, 366, 1–4. <https://doi.org/10.1136/bmj.l4256>
- Spivak, G. (1996). Poststructuralism, marginality, postcoloniality and value. In P. Mongia (Ed.) *Contemporary postcolonial theory: a reader* (pp. 198-222). New York; London : Arnold.
- Standing Committee on Citizenship and Immigration. (2017). *Improving Government Oversight of Immigration Consultants*.
<https://www.ourcommons.ca/DocumentViewer/en/42-1/CIMM/report-11/response-8512-421-255>
- Standing Committee on Citizenship and Immigration. (2009). *Migrant Workers and Ghost Consultants: Report of the Standing Committee on Citizenship and Immigration*. Retrieved from
https://www.ourcommons.ca/Content/Committee/402/CIMM/Reports/RP3969226/402_CIMM_Rpt08/402_CIMM_Rpt08-e.pdf
- Stasiulis, D. (2012). Revisiting the permanent-temporary labour migration dichotomy. In Pellerin, H. (Ed.). *Governing international labour migration: Current issues, challenges and dilemmas*. *Governing International Labour Migration: Current Issues, Challenges and Dilemmas*.
- Statistics Canada. (2022). Immigration as a source of labour supply.
<https://www150.statcan.gc.ca/n1/daily-quotidien/220622/dq220622c-eng.htm>
- Straehle, C. (2013). *Conditions of care: Migration, vulnerability, and individual autonomy* . *IJFAB: International Journal of Feminist Approaches to Bioethics*. Indiana University Press.

- Tedlock, B. (2003). Ethnography and ethnographic representation. In N.K. Denzin & Y.S. Lincoln (Eds.), *Strategies of Qualitative Inquiry* (pp. 165-213). Thousand Oaks : Sage Publications.
- Torres, S., Spitzer, D.L., Hughes, K.D., Oxman-Martinez, J., & Hanley, J. (2012). From temporary worker to resident: The live-in caregiver program and its impact through an intersectional lens. In Lenard, P. T., & Straehle, C. (Eds.). *Legislated inequality: temporary labour migration in Canada*. McGill-Queen's University Press.
- Tungohan, E., Banerjee, R., Chu, W., Cleto, P., De Leon, C., Garcia, M., Kelly, P., Luciano, M., Palmaria, C., & Sorio, C. (2015). After the Live-In Caregiver Program: Filipina Caregivers' Experience and Uneven Citizenship. *Canadian Ethnic Studies*, 47(1), 87–105
- Tungohan, E. (2019). Global care chains and the spectral histories of care migration. *International Journal of Care and Caring*, 3(2), 229–245.
<https://doi.org/10.1332/239788218X15411704809877>
- Tungohan, E. (2020). Settlement, separation and forming new families: A multi-scalar intersectional analysis of Filipino family immigration in Saskatchewan, Canada. *Women's Studies International Forum*, 83(July), 102403.
<https://doi.org/10.1016/j.wsif.2020.102403>
- Vahabi, M., & Wong, J. P. (2017). Caught between a rock and a hard place : mental health of migrant live-in caregivers in Canada. *BMC Public Health*, 17(498), 1–15.
<https://doi.org/10.1186/s12889-017-4431-4>
- Valiani, S. (2012). The shifting landscape of contemporary Canadian immigration policy: The rise of temporary migration and employer-driven immigration. In L. Goldring & P. Landolt (Eds.), *Producing and Negotiating Non-Citizenship: Precarious Legal Status in Canada* (pp. 55–70). University of Toronto Press.
<https://doi.org/10.3138/9781442663862-007>

- Varona, R. (2013). *License to exploit: A report on the recruitment practices and problems experienced by Filipino domestic workers in Hong Kong*. Alliance of Progressive Labor-Hong Kong (APL-HK) and the Progressive Labor Union of Domestic Workers in Hong Kong (PLU). Quezon City.
- Walia H. Transient servitude: Migrant labour in Canada and the apartheid of citizenship. *Race Class 2010*, 52(1),71-84. doi: 10.1177/0306396810371766.
- Wee, K., Goh, C., & Yeoh, B. S. A. (2019). Chutes-and-ladders: the migration industry, conditionality, and the production of precarity among migrant domestic workers in Singapore. *Journal of Ethnic and Migration Studies*, 45(14), 2672–2688.
<https://doi.org/10.1080/1369183X.2018.1528099>
- Whittemore, R., Chao, A., Jang, M., Mingos, K. E., & Park, C. (2014). Methods for knowledge synthesis: An overview. *Heart and Lung: Journal of Acute and Critical Care*, 43(5), 453–461. <https://doi.org/10.1016/j.hrtlng.2014.05.014>
- World Health Organization. (2017). *Women on the move*. Geneva. Retrieved from <https://www.who.int/publications/i/item/women-on-the-move-migration-care-work-and-health>
- Wray, S., & Bartholomew, M. (2014). Some reflections on outsider and insider identities in ethnic and migrant qualitative research. *Migration Letters*, 7(1), 7–16.
<https://doi.org/10.33182/ml.v7i1.176>
- Yssaad, L. & Fields, A. (2018). *The Canadian Immigrant Labour Market: Recent Trends from 2006 to 2017*. Statistics Canada. <https://www150.statcan.gc.ca/n1/pub/71-606-x/71-606-x2018001-eng.htm>
- Yeates, N. (2012). *Global care chains: A state-of-the-art review and future directions in care transnationalization research* Blackwell Publishing Ltd. doi:10.1111/j.1471-0374.2012.00344.x

Zimmerman, C., Kiss, L., & Hossain, M. (2011). Migration and Health : A Framework for 21st Century. *PLoS Medicine*, 8(5).

<https://doi.org/10.1371/journal.pmed.1001034>

Appendices

Appendix A: Letter of information and consent for caregivers



Project Title

Examining the Socio-Economic and Gendered Structure of Canada's Caregiver Program: A Qualitative Study of Filipino Women's Health Experiences

Document Title

Letter of Information and Consent – Caregivers

Principal Investigator + Contact

Principal Investigator

Dr. Treena Orchard, PhD
Arthur and Sonia Labatt Health Sciences Building, Rm. 208
Faculty of Health Sciences, Western University
London, ON, Canada N6A 5B9

Additional Research Staff + Contact

Additional Research Staff

Andrea Bobadilla, MSc, PhD(c)
Elborn College, Rm. 1014
Health and Rehabilitation Sciences, Western University
London, ON, Canada N6G 1H1

1. Invitation to Participate

Introduction

You are invited to take part in interviews I am doing with women who have participated in the Live-In Caregiver Program (LCP) as part of a study on the health experiences of Filipina women who have migrated to Canada through the Caregiver program. As a doctoral student from Western University, I want to understand how the structure of the LCP and experiences of migration impact women's health. I would also like to gain insight into how women in the program manage their own health needs in between caring for their employers and family in the Philippines. While research has been done on the employment conditions the LCP produces, very little has been written about the consequences for caregivers' health and well-being. Your experiences and ideas are very valuable, and that is why I am asking you to take part in the project.

2. Why is this study being done?

The purpose of this study is to explore how the LCP may produce health disparities among caregivers. The aim of the study is to understand how women in the LCP manage their health and respond to the occupational challenges of performing care work in Canada, in light of their family's health needs in the Philippines. I also want to learn about the types of health challenges and barriers women in the LCP may experience and the strategies they use to meet their needs.

3. How long will you be in this study?

It is expected that you will be in the study for two interviews and each interview will last approximately one hour.

4. What are the study procedures?

If you agree to participate you will be asked to take part in two interviews, each lasting approximately one hour and taking place at the Philippines Women's Centre of Ontario or the Caregivers Action Centre. Interviews will be open-ended and you will have the opportunity to discuss your experiences of migration and health as well as your decision to participate in the LCP. The interviews will ideally be recorded on a digital voice recorder and will be typed out word for word on a computer so that I have a complete record of what is said. If you wish to take part in the study, but do not feel comfortable being audio-recorded, you may still participate in interviews and written hand notes will be taken instead. During the second interview, you will have the chance to review the transcript of the initial interview for accuracy and you may request to make changes at that time.

5. What are the risks and harms of participating in this study?

I do not anticipate that participation in this study will result in any distress or harm for you. However, some issues may be difficult to talk about and could generate emotional and psychological stress; or they may trigger previously traumatic experiences. If you do experience any discomfort, distress, or other emotional difficulties during the interview I will be able to provide you with the name of support staff (off and on-site) and the appropriate referral. Staff at both agencies are experienced and trained to deal with issues of migration that can be potentially emotionally distressing or cause anxiety. I will also make every effort to help you feel at ease throughout the process and each interview by ensuring that your privacy, anonymity, and confidentiality are respected at all times as well as your freedom to share as much or as little about your story as you feel comfortable with.

6. What are the benefits?

The primary benefit of this study is that it honours and seeks to better understand the experiences of women in the LCP from their own perspective and in their own words. Caregivers have often expressed feelings of social and cultural isolation and the stress of doing care work and this study is an opportunity to validate and consider their views on how the LCP may affect their health.

7. Can participants choose to leave the study?

If you decide to withdraw from the study, you have the right to request withdrawal of information collected about you. If you wish to have your information removed please let the researcher know.

8. How will participants information be kept confidential?

Confidentiality of the information you disclose is respected and protected. I will not report any information that identifies you and all information obtained will be made and kept anonymous. This includes any personal names you may divulge during the interviews, which will be changed when your data is incorporated into reports, presentations, or publications. You will be asked to read this information and sign the consent form, and after that a study number will be given to you instead of using your real name during the study. By doing this, information gathered will contain numbers and not names, which means that no one will be able to identify you. The researcher will keep any personal information about you in a secure and confidential location for five years. A list linking your study number with your name will be kept by the researcher in a secure place, separate from your study file.

Only myself and the lead researcher will have access to the information from the study. While we do our best to protect your information there is no guarantee that we will be able to do so. If data is collected during the project which may be required to report by law we have a duty to report. Representatives of The University of Western Ontario Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.

The information from the study, which will not contain any identifiable information, may be used to create reports to be presented at scientific conferences and academic journals. It is also my hope that the information will be used during the development of programs to assist caregivers access health services.

9. Are participants compensated to be in this study?

You will be compensated with an honorarium of \$20 for your time and participation in this study at the end of each activity you take part in.

10. What are the Rights of Participants?

Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study at any time. If you choose not to participate or to leave the study at any time it will have no effect on your involvement with the Philippines Women's Centre, the Caregivers Action Centre, or any affiliated organization.

We will give you new information that is learned during the study that might affect your decision to stay in the study.

You do not waive any legal right by signing this consent form.

11. Whom do participants contact for questions?

If you have questions about this research study please contact the Principal Investigator:
Treena Orchard, Ph.D.
Assistant Professor
School of Health Studies
Western University
Phone: [REDACTED]

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics (519) 661-3036, email: ethics@uwo.ca.

12. Consent

Written Consent

1. Project Title

Examining the Socio-Economic and Gendered Structure of Canada's Caregiver Program: A Qualitative Study of Filipino Women's Health Experiences

2. Document Title

Letter of Information and Consent – Caregivers

3. Principal Investigator + Contact

Principal Investigator

Dr. Treena Orchard, PhD
Arthur and Sonia Labatt Health Sciences Building, Rm. 208
Faculty of Health Sciences, Western University
London, ON, Canada N6A 5B9

4. Additional Research Staff + Contact

Additional Research Staff

Andrea Bobadilla, MSc, PhD(c)
Elborn College, Rm. 1014
Health and Rehabilitation Sciences, Western University
London, ON, Canada N6G 1H1

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

I agree to be audio-recorded in this research

YES NO

I consent to the use of unidentified quotes obtained during the study in the dissemination of this research

YES NO

Appendix B : Letter of information and consent for key informants



Project Title

Examining the Socio-Economic and Gendered Structure of Canada's Caregiver Program: A Qualitative Study of Filipino Women's Health Experiences

Document Title

Letter of Information and Consent – Key Informants

Principal Investigator + Contact

Principal Investigator

Dr. Treena Orchard, PhD
Arthur and Sonia Labatt Health Sciences Building, Rm. 208
Faculty of Health Sciences, Western University
London, ON, Canada N6A 5B9

Additional Research Staff + Contact

Additional Research Staff

Andrea Bobadilla, MSc, PhD(c)
Elborn College, Rm. 1014
Health and Rehabilitation Sciences, Western University
London, ON, Canada N6G 1H1

1. Invitation to Participate

Introduction

You are invited to take part in interviews I am doing with key informants whose work is in relation to the Canadian Live-In Caregiver Program (LCP) as part of a study on the health experiences of Filipina women who have migrated to Canada through the Caregiver program. As a doctoral student from Western University, I want to understand how the structure of the LCP and experiences of migration impacts women's health. I would also like to gain insight into how women in the program manage their own health needs in between caring for their employers and family in the Philippines. While research has been done on the employment conditions the LCP produces, very little has been written about the consequences for caregivers' health and well-being. Your experiences and ideas are very valuable, and that is why I am asking you to take part in the project.

2. Why is this study being done?

The purpose of this study is to explore how the LCP may produce health disparities among caregivers. The aim of the study is to understand how women in the LCP manage their health and respond to the occupational challenges of performing care work in Canada, in light of their family's health needs in the Philippines. I also want to learn about the types of health challenges and barriers women in the LCP may experience and the strategies they use to meet their needs.

3. How long will you be in this study?

It is expected that you will be in the study for one interview, lasting approximately thirty minutes to one hour.

4. What are the study procedures?

If you agree to participate you will be asked to take part in one interview lasting approximately thirty minutes to one hour, at the Philippines Women's Centre of Ontario, the Caregivers Action Centre, or a place of your own choosing. Interviews will be open-ended and you will have the opportunity to discuss your work with women in the LCP or your involvement with the program. The interviews will be recorded on a digital voice recorder and will be typed out word for word on a computer so that I have a complete record of what is said. If you wish to take part in the study, but do not feel comfortable being audio-recorded, you may still participate in interviews and written hand notes will be taken instead.

5. What are the risks and harms of participating in this study?

I do not anticipate that participation in this study will result in any distress or harm for you. However, some issues may be difficult to talk about and could generate emotional and psychological stress related to previous tenuous experiences or conflicts working with or on behalf of those in the LCP. If you do experience any discomfort, distress, or other emotional difficulties during the research I will be able to provide you with the name of off-site support services and the appropriate referral. I will also make every effort to help you feel at ease throughout the process and each interview by ensuring that your privacy, anonymity, and confidentiality are respected at all times as well as your freedom to share as much or as little about your work as you feel comfortable with.

6. What are the benefits?

The primary benefit of this study is that it honours and seeks to better understand the experiences of women in the LCP from their own perspective and in their own

words. Caregivers have often expressed feelings of social and cultural isolation and the stress of doing care work and this study is an opportunity to validate and consider their views on how the LCP may affect their health. Advocates as well as healthcare and social service providers have also described the problematic structure of the LCP and its potentially negative health consequences for caregivers as well as the limitations they have in protecting their health. This study will also collect information on the effects of the policy on their jobs and duties as healthcare and social service providers.

7. Can participants choose to leave the study?

If you decide to withdraw from the study, you have the right to request withdrawal of information collected about you. If you wish to have your information removed please let the researcher know.

8. How will participants information be kept confidential?

Confidentiality of the information you disclose is respected and protected. I will not report any information that identifies you and all information obtained will be made and kept anonymous. This includes any personal names you may divulge during the interviews, which will be changed when your data is incorporated into reports, presentations, or publications. You will be asked to read this information and sign the consent form, and after that a study number will be given to you instead of using your real name during the study. By doing this, information gathered will contain numbers and not names, which means that no one will be able to identify you. The researcher will keep any personal information about you in a secure and confidential location for five years. A list linking your study number with your name will be kept by the researcher in a secure place, separate from your study file.

Only myself and the lead researcher will have access to the information from the study. While we do our best to protect your information there is no guarantee that we will be able to do so. If data is collected during the project which may be required to report by law we have a duty to report. Representatives of The University of Western Ontario Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.

The information from the study, which will not contain any identifiable information, may be used to create reports to be presented at scientific conferences and academic journals. It is also my hope that the information will be used during the development of programs to assist caregivers access health services.

9. Are participants compensated to be in this study?

No honorariums will be provided for participation in this study.

10. What are the Rights of Participants?

Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study at any time. If you choose not to participate or to leave the study at any time it will have no effect on your employment, work, or involvement with the Philippines Women's Centre, the Caregivers Action Centre, or any affiliated organization.

We will give you new information that is learned during the study that might affect your decision to stay in the study.

You do not waive any legal right by signing this consent form.

11. Whom do participants contact for questions?

If you have questions about this research study please contact the
Principal Investigator:
Treena Orchard, Ph.D.
Assistant Professor
School of Health Studies
Western University
[REDACTED]

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Research Ethics (519) 661-3036, email: ethics@uwo.ca.

12. Consent**Written Consent****1. Project Title**

Examining the Socio-Economic and Gendered Structure of Canada's Caregiver Program: A Qualitative Study of Filipino Women's Health Experiences

2. Document Title

Letter of Information and Consent – Key Informants

3. Principal Investigator + Contact**Principal Investigator**

Dr. Treena Orchard, PhD
Arthur and Sonia Labatt Health Sciences Building, Rm. 208
Faculty of Health Sciences, Western University
London, ON, Canada N6A 5B9

4. Additional Research Staff + Contact**Additional Research Staff**

Andrea Bobadilla, MSc, PhD(c)
Elborn College, Rm. 1014
Health and Rehabilitation Sciences, Western University
London, ON, Canada N6G 1H1

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

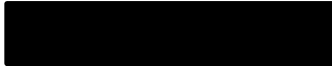
I agree to be audio-recorded in this research

YES NO

I consent to the use of unidentified quotes obtained during the study in the dissemination of this research

YES NO

Appendix C : Recruitment poster for caregivers



PARTICIPANTS NEEDED FOR RESEARCH ON HEALTH-RELATED EXPERIENCES OF WOMEN IN THE CAREGIVER PROGRAM

We are looking for volunteers to take part in a study of **the health-related experiences of women who have participated in the Canadian Caregiver Program, formerly known as the Live-In Caregiver Program**, who meet the following criteria:

- **Female;**
- **Migrated from the Philippines to Ontario through the live-in caregiver program from the year 2000 to present;**
- **Speak some English;**
- **Between the ages of 20 to 60 years old**

If you are interested and agree to participate you would be asked to: **take part in two one-on-one interviews.**

Your participation would involve **two interviews**, each session will be about **60 minutes** long.

In appreciation for your time, you will receive **\$20** for each interview, thus a potential total \$40 as an honorarium.

For more information about this study, or to volunteer for this study, please contact:

Andrea Bobadilla
Health and Rehabilitation Sciences



Version: 17/05/2016



Appendix D: Recruitment poster for key informants



PARTICIPANTS NEEDED FOR RESEARCH ON HEALTH-RELATED EXPERIENCES OF WOMEN IN THE CAREGIVER PROGRAM

We are looking for volunteers to take part in a study of **the health-related experiences of women who have participated in the Canadian Caregiver Program, formerly known as the Live-In Caregiver Program**, who meet the following criteria:

- **Works with, volunteers, advocates or serves those in the Canadian Caregiver program or potential applicants**
- **Must speak English;**
- **Between the ages of 20 to 60 years old**

If you are interested and agree to participate you would be asked to: **take part in one one-on-one interview.**

Your participation would involve **one interview**, each session will be about **20-60 minutes** long.

For more information about this study, or to volunteer for this study, please contact:

Andrea Bobadilla
Health and Rehabilitation Sciences



Appendix E: Life history interview guide for caregivers

Interview Guide – Caregivers Life History Interview

Can you tell me about your story of coming to join the Caregiver program? You may include as much or as little detail as you would like. Feel free to begin whenever you are ready.

Probing Questions:

1. Can you tell me your age and how long you've been in Canada for?
2. Where in the Philippines are you and your family from?
3. Can you describe what your family in the Philippines is like?
4. Have you ever gone back to the Philippines? If so, how often and for how long?
5. Before applying for the Caregiver program, what did you do for work?
6. What types of training or schooling did you do before applying to the program?
7. How did you come to learn about the Canadian Caregiver program?
8. What attracted you to come to Canada and not another country?
9. Why did you choose to apply to the caregiver program and not another immigration category?
10. How old were you when you began the process of applying for the Caregiver program?
 - a. When did you know you were accepted to the program?
11. Can you describe how you made the decision to emigrate?
12. Can you tell me about the process of leaving the Philippines and coming to Canada?
13. What was it like preparing to leave for Canada?
 - a. What resources did you have to use to come here (for the application, recruitment, plane ticket, education, training)?
 - b. Do you think you were given enough information about the program and what it would be like when you arrived here?
14. What did your family (partner, children, parents, extended family) think when you began applying to emigrate?
 - a. How do they feel about you being here now?
15. What has your experience been like since you came here?
 - a. What's your relationship like with your employer? Who you care for?
16. Can you describe what a typical day is like caring for your client?
17. What types of challenges do you face in doing care work?
 - a. How do you cope with these challenges?
18. Do any of your jobs demands ever interfere with responsibilities you have to your family back home?
19. Has your job ever come between any obligations you have back home?
20. Can you describe any difficulties back home that may contribute to encouraging you to continue to work as a caregiver in Canada?
21. What are your family's expectations of the type and extent of support you can provide them while in Canada?

22. What types of strategies do you use to manage the expectations of your employer in Canada and your family's needs back home?
23. What types of activities do you do for leisure?
24. Have you ever felt sick during the time you were in Canada?
 - a. If so, how did you take care of yourself? Did you attempt to access any health services? If so, can you tell me what your experience was like?
 - b. What was your employer's response to your sickness?
25. What sources of formal support, such as health services, have you attempted to access while in Canada?
 - a. How difficult do you think it is to get this support when you need it?
26. What about informal support, such as that of peers, friends, or family, do you rely on in Canada?

Appendix F: Key informant interview guide

Interview Guide - Key Informants

1. Can you describe the type of work your organization does?
2. Can you explain what your role is within the organization?
3. How long have you been in your current role?
4. How often do you work with/see caregivers?
5. Could you describe the type of work you do with caregivers specifically?
6. What types of issues are usually raised during your time with them? What types of things do they come in to see you about?
 - a. How frequently does this happen?
 - b. How difficult is it to address their concerns?
 - c. What challenges do you face in trying to help caregivers?
7. In trying to serve caregivers, who else do you often have to work with in order to resolve issues (i.e. employers, recruitment agencies)?
 - a. How cooperative are each of these stakeholders in trying to help caregivers?
 - b. Can you describe any difficulties you may encounter while working with them?
8. What impacts, if any, do you believe participating in the Caregiver program may have on women's physical and/or mental health?

Appendix G: Research protocol ethics approval notice



Research Ethics

Western University Non-Medical Research Ethics Board NMREB Full Board Initial Approval Notice

Principal Investigator: Dr. Treena Orchard
Department & Institution: Health Sciences\Nursing, Western University

NMREB File Number: 108011
Study Title: Examining the Socio-Economic and Gendered Structure of Canada's Caregiver Program: A Qualitative Study of Filipino Women's Health Experiences

NMREB Initial Approval Date: June 08, 2016
NMREB Expiry Date: June 08, 2017

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Instruments	Interview Guide (Caregivers and Key Informants)	2016/04/22
Western University Protocol	Received May 25, 2016	
Letter of Information & Consent	Key Informants	2016/05/24
Letter of Information & Consent	Caregivers	2016/05/17
Other	Confidentiality Agreement - Caregiver Support Staff	2016/05/23
Recruitment Items	Recruitment Script - Caregivers	2016/05/17
Recruitment Items	Recruitment Script - Key Informants	2016/05/17
Recruitment Items	Recruitment Poster - Key Informants	2016/05/18
Recruitment Items	Recruitment Poster - Caregivers	2016/05/17

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the above named study, as of the NMREB Initial Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 0000941.

[Redacted Signature]
Ethics Officer, on behalf of Dr. Riley Hinson, NMREB Chair

Ethics Officer: Erika Basile ___ Nicole Kaniki ___ Grace Kelly ___ Katelyn Harris ___ Vikki Tran Karen Gopaul ___

Curriculum Vitae

Name: Andrea Bobadilla

Post-secondary Education and Degrees:

The University of Western Ontario
London, Ontario, Canada
2007-2011 BHSc Honors Specialization, Health Sciences

The University of Western Ontario
London, Ontario, Canada
2011-2013 MSc Health and Rehabilitation Sciences

The University of Western Ontario
London, Ontario, Canada
2013-2022 PhD Health and Rehabilitation Sciences

Related Work Experience

Research Associate
Social Research and Demonstration Corporation
2019-2022

Research Coordinator
University of Toronto
2018-2019

Research Assistant
The University of Western Ontario
2015

Teaching Assistant
The University of Western Ontario
2011-2016

Publications:

Bobadilla, A., Orchard, T., Magalhaes, L and Fitzsimmons, D. (Accepted 2016, July). "Ontario healthcare coverage eligibility among new permanent residents: a scoping review". *Journal of Immigration & Refugee Studies*.
<http://dx.doi.org/10.1080/15562948.2016.1214993>

Huot, S., Bobadilla, A., Laliberte-Rudman, D. and Baillaird, A. (Accepted 2015, September). "Constructing undesirables: A critical discourse analysis of 'othering' within the Protecting Canada's Immigration System Act". *International Migration*.
doi: 10.1111/imig.12210

Bobadilla, A. (2013). "Oh, so we're not insured?": Exploring the impact of Ontario's Health Insurance Plan on new permanent residents and health care providers. London, ON: School of Graduate and Postdoctoral Studies, University of Western Ontario.

Presentations:

Bobadilla, A. (2019, June). "My time is already running out": The role of non-state actors on the stepwise migration of Filipina care workers to Canada. Paper accepted for the International Metropolis Conference. Ottawa, ON.

Bobadilla, A. (2019, June). Getting carework experience: the influence of stepwise carework migrations on Filipina careworkers in Canada. Paper accepted for the Global Carework Summit. Toronto, ON.

Bobadilla, A., Huot, S., Bailliard, A., & Laliberte Rudman, D. (2017, April). Reproducing stereotypes of asylum seekers through designations in the 'Protecting Canada's Immigration System Act'. Paper accepted for the University of Ottawa Migration/Representation/Stereotypes Conference. Ottawa, ON.

Bobadilla, A. (2016, June). Examining the Socio-Economic and Gendered Structure of Canada's Caregiver Program: A Qualitative Study of Filipino Women's Health Experiences in Southern Ontario. Health, Medicine and Mobility: International Migrations in Historical Perspective Conference. University of Prince Edward Island, Charlottetown, PEI.

Huot, S., Bobadilla, A., Bailliard, A., & Laliberte Rudman, D. (2016, March). Social injustice of designations in the 'Protecting Canada's Immigration System Act': Producing differential mobility of asylum seekers. Paper accepted for the American Association of Geographers Annual Meeting. San Francisco, CA.

Huot, S., Bobadilla, A., Bailliard, A., & Laliberte Rudman, D. (2015, November). Discursive constructions of asylum seekers as the 'other' in the Protecting Canada's Immigration System Act. Poster accepted for the Pathways to Prosperity National Conference. Toronto, ON.

Bobadilla, A., Huot, S., Laliberte-Rudman, D. and Baillaird, A. (2014, April). Discursively constructing the 'other' in the Protecting Canada's Immigration System Act. Oral presentation at the 2015 Centre for Migration and Ethnic Relation Graduate Student Conference: Interdisciplinary Perspectives on Migration and Settlement. Western University, London, ON.

Bobadilla, A. (2014, April). "If everything goes right": Exploring the impact of OHIP on new permanent residents. Oral presentation at the Collaborative Immigration and Settlement Studies (Ryerson University) and Migration and Ethnic Relations (Western

University) Mobility and Immobility: Interdisciplinary Perspectives on Migration and Settlement Graduate Conference. Western University, London, ON.

Bobadilla, A. (2014, March). "We had a plan": Exploring the impact of OHIP on new permanent residents. Poster accepted at the University of Toronto International Health Program Health and Human Rights Conference. University of Toronto, Toronto, ON.

Bobadilla, A. (2014, March). Negotiating migrant status and health: Experiences of health among new permanent residents in the three-month wait period. Invited presentation for the Health and Wellbeing Subcouncil of the London & Middlesex Local Immigration Partnership, London, ON.

Bobadilla, A. (2014, March). "We had a plan": Exploring the impact of OHIP on new permanent residents. Poster presentation at the 16th National Metropolis Conference, Gatineau, QC.

Bobadilla, A. (2013, November). "If everything goes right": Exploring the impact of OHIP on new permanent residents. Poster presentation at the Queen's Health and Human Rights Conference 2013, Queen's University, Kingston, ON.

Bobadilla, A. (2013, February). "Chasing paper": Experiences of new immigrants to Ontario with the Ontario Health Insurance Plan's three-month wait period. Oral presentation at the Health and Rehabilitation Sciences Graduate Research Forum 2013, University of Western Ontario, London, ON.