

**“All for the Family”: A Case Study on the Migration of Philippine Educated Nurses to
Ontario through the Live-in Caregiver Program**

by

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ABSTRACT

Despite evidence that suggests that nurses migrate to Ontario through the Live-in Caregiver Program, no research has been conducted on this group of nurses in Ontario. This study addresses that gap utilizing the transnational feminist concept of “global care chains” in a single holistic case study design to explore the experience of nurses who migrate to Ontario through the Live-in Caregiver Program (2001-2011), and examine the diverse perspectives of stakeholders on issues of rights and obligations of these nurses. Fifteen live-in caregivers and nine policy stakeholders were interviewed, and an analysis undertaken of immigration and nursing policy documents. Findings indicate that familial discourses and perspectives on global social status shape these women’s decision to migrate from the Philippines to Canada, often via a second country (especially Saudi Arabia), as well as their subsequent Canadian experiences. Results are consistent with Rhacel Parrenas’ idea of ‘contradictory class mobility’ that describes the phenomenon of decrease in social status coupled with an increase in financial status among immigrant care workers. As professional women undertaking unskilled work, the nurses’ contradictory class status was reinforced by the emotional labour and domestic work they were required to perform. Furthermore, as temporary workers on a path to permanent residency, their professional integration as nurses was complicated by Canada’s immigration policy and the

paradox between the government's stated short-term goal (to address labour force shortage of live-in caregivers) versus its long-term goal (to ensure the integration of permanent residents). Within this policy paradox immigration policy makers emphasized the short-term obligation of fulfilling labour needs, while live-in caregivers and advocacy groups emphasized the long-term obligations of the Canadian government related to gaining permanent residence status. The lack of congruence between the Live-in Caregiver Program policy and nursing policy concerning internationally educated nurses, as well as prioritization of their familial obligations complicated the process of professional integration for this group of women. Recommendations arising from the study concern the need to bridge these policy gaps and address the shortcomings of the Live-in Caregiver Program to leverage the integration of this group of internationally educated nurses in Canada.

DEDICATION

I dedicate this dissertation to all women who make sacrifices for the future of their children,
especially my mom, Felicia Kolawole.

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Table of Contents

ABSTRACT.....	ii
DEDICATION	iv
ACKNOWLEDGEMENTS	v
CHAPTER 1: INTRODUCTION AND BACKGROUND	1
INTRODUCTION	1
CANADIAN IMMIGRATION.....	7
Introduction to Canada’s Immigration System	7
LIVE-IN CAREGIVER PROGRAM	11
History of the Live-in Caregiver Program in Canada	11
Current Live-in Caregiver Program	13
NURSING WORKFORCE.....	16
Canadian Nursing Workforce	16
Nursing Workforce in Ontario	17
SUMMARY OF BACKGROUND.....	19
CHAPTER 2: LITERATURE REVIEW	21
IMMIGRANTS IN CANADA.....	21
Immigrants’ Labour Market Experience.....	21
Immigrant Women’s Labour Market Experience	23
NURSING WORKFORCE / MIGRATION.....	26
Barriers to Workforce Integration of Internationally Educated Nurses	27
Global Health Workforce and Ethics	31
Nurse Migration from the Philippines	34
DOMESTIC WORKERS AND LIVE-IN CAREGIVERS	37

Global Migration of Domestic Workers	37
Statistics on Canada’s Live-in Caregiver Program	43
Research on Canada’s Live-in Caregiver Program.....	43
Research on Nurse Migration through the Live-in Caregiver Program	48
IMMIGRATION POLICY AND CURRENT INITIATIVES.....	54
Policy on Temporary Foreign Worker Program (including the Live-in Caregiver Program).....	54
Current Initiatives on Immigrant Integration	57
SUMMARY OF LITERATURE REVIEW	61
RESEARCH PROBLEM.....	63
RESEARCH PURPOSE AND QUESTION.....	63
CHAPTER 3: THEORETICAL FRAMEWORK.....	65
INTRODUCTION	65
THEORETICAL BACKGROUND ON THE GLOBAL CARE CHAIN: EMOTIONAL LABOUR...	65
GLOBAL CARE CHAINS.....	68
LEVELS OF ANALYSIS OF GLOBAL CARE CHAINS OF DOMESTIC WORKERS	71
Macro Level Analysis	72
Intermediate Level Analysis	74
Subject or Micro Level Analysis	75
PARRENAS’ DISLOCATIONS	76
The Pain of Family Separation.....	77
Feeling of Social Exclusion and Non-Belonging.....	78
Contradictory Class Mobility.....	78
Partial Citizenship.....	80
CARENS ON RIGHTS OF TEMPORARY WORKERS IN CANADA	81
CONCLUSION OF THEORETICAL FRAMEWORK	85

CHAPTER 4: METHODOLOGY	87
INTRODUCTION	87
CASE STUDY METHODOLOGY	87
DATA COLLECTION AND UNIT OF ANALYSIS	90
DATA SOURCES	93
Data Source 1: Document Analysis	93
Data Source 2: Live-in Caregiver Interviews.....	95
Data Source 3: Interviews with Canadian Key Stakeholders.....	101
QUALITY IN QUALITATIVE CASE STUDY RESEARCH	102
POSITIONALITY AND REFLEXIVITY	104
RESEARCH ETHICS.....	106
Informed Consent.....	106
Confidentiality and Anonymity	107
Risks and Benefits.....	108
Compensation	109
Conflict of Interest	109
DATA ANALYSIS.....	110
CONCLUSION OF METHODOLOGY.....	114
CHAPTER 5: “WHY ARE YOU INTERESTED IN US”: REFLEXIVE ENGAGEMENT IN THE FIELD	116
CHAPTER 6: RESULTS 1: “ALL FOR THE FAMILY”: MIGRATION TO CANADA	122
INTRODUCTION	122
KRISTINE’S STORY	122
MOTIVATIONS FOR MIGRATION	124
Economic Motivation for Emigrating from the Philippines: “Because my mom told me”	124

Economic and Social Class as a Motivation: Migration from the Philippines to the Middle East to Canada.....	126
Lifestyle as Motivation: Migrating from the Middle East to Canada	130
Canadian Citizenship as a Motivation: “All for the Family”	131
REASONS FOR NOT MIGRATING TO CANADA AS A SKILLED WORKER	133
SOURCES OF MIGRATION INFORMATION.....	137
Getting Information from Networks	137
The Role of Recruitment Agencies	138
PRE-MIGRATION EXPECTATIONS	143
SUMMARY AND CONCLUSION.....	145
CHAPTER 7: RESULTS 2: EXPERIENCE IN CANADA	147
INTRODUCTION	147
PART A: “THERE IS A CHANCE THAT THEY WILL NOT ACCEPT ME”: THE EXPERIENCE OF PARTIAL CITIZENSHIP AND NON-BELONGING.....	148
Introduction.....	148
Seeking Work Permit.....	148
Seeking Permanent Resident Status in Canada.....	150
Negotiating Non-Citizenship: Creating Support Systems.....	153
Negotiating Non-Citizenship: Use of Weekend Homes	155
Conclusion	156
PART B: EMPLOYER AND EMPLOYEE RELATIONSHIP: “I AM SLAVE AND THEY ARE MASTER”	158
Introduction.....	158
Positive Employer-Employee Relationship	158
Positive Relationship with Recipient of Care	161
Negative Employer-Employee Relationship and Conflict: “Tragic Trauma”	162
“One of the Family”: Familial Versus Employer-Employee Relationship.....	166

Negotiating the Employer-Employee Relationship	168
Conclusion	170
PART C: PAIN OF FAMILY SEPARATION	172
Introduction.....	172
Pain Related to Separation from their Children	172
Marital Separation.....	174
Challenging Pain of Family Separation	175
Conclusion	177
PART D: CONTRADICTIONS IN CLASS MOBILITY	178
Introduction.....	178
Becoming a Nurse in Canada: Leah’s Story	178
Downward Mobility and Deskilling	179
Barriers and Facilitators to Becoming a Nurse in Ontario.....	183
Contradictory Employer Support.....	183
Credential Assessment	185
Access to Bridging Programs.....	189
Cost.....	191
Passing Nursing Exams and Language Exams	192
Negotiating Contradictory Class Mobility.....	194
CONCLUSION: EXPERIENCE IN CANADA	197
CHAPTER 8: RESULTS 3: RIGHTS AND OBLIGATIONS OF DIVERSE STAKEHOLDERS	199
INTRODUCTION	199
LIVE-IN CAREGIVER RIGHTS.....	200
RIGHTS AND OBLIGATIONS OF NURSES WHO MIGRATE TO CANADA THROUGH THE LIVE-IN CAREGIVER PROGRAM	205
OBLIGATIONS OF STAKEHOLDERS	208
Obligations of Employers	208

Obligations of Recruiters	210
Obligations of Immigration Policy Makers.....	212
Obligations of Nursing Policy Makers.....	216
Obligations of Educators.....	218
CONCLUSION.....	218
CHAPTER 9: DISCUSSION AND CONCLUSION	221
INTRODUCTION	221
INFLUENCE OF GENDER AND CLASS IN TWO-STEP MIGRATION	222
Two-Step Migration: Philippines to the Middle East to Canada	222
Gendered Sacrifice: “All for the Family”	224
Contradictory Class Mobility and Discourse on Social Position	226
LABOUR AND EMOTIONAL LABOUR IN LIVE-IN CAREGIVER WORK.....	228
Pre-Migration Constructions of Labour	229
Emotional Labour in Live-in Caregiver Work.....	230
Emotional Displacement of Love	234
Familial Discourse: (Not) One of the Family	235
NURSING WORKFORCE INTEGRATION.....	237
Familial Obligations.....	238
Employer’s Role in Integration.....	239
Credential Assessment and Recognition.....	240
Access to Bridging Program	242
OBLIGATIONS OF STAKEHOLDERS	244
LIMITATIONS OF THE STUDY.....	247
IMPLICATIONS OF THE STUDY	249
Implications for Immigration and Public Policy	250

Implications for Global Childcare and Eldercare Policy	253
Implications for Nursing Policy	254
Implications for Research	257
FINAL CONCLUDING STATEMENT	258
REFERENCES	261
TABLES	290
TABLE 1: DESTINATION PROVINCE OF LIVE-IN CAREGIVERS WHO MIGRATED IN 2009	291
TABLE 2: LIVE-IN CAREGIVER PRINCIPAL APPLICANTS WITH PROFESSIONAL OCCUPATIONS IN HEALTH, 2005-2009*	292
TABLE 3: LIVE-IN CAREGIVER PRINCIPAL APPLICANTS WITH PROFESSIONAL OCCUPATIONS IN HEALTH BY EDUCATION LEVEL, 2005-2009*	293
TABLE 4 – LIVE-IN CAREGIVER PRINCIPAL APPLICANTS WITH PROFESSIONAL OCCUPATIONS IN HEALTH BY COUNTRY OF LAST PERMANENT RESIDENCE, 2005-2009*	294
APPENDIX A: LIST OF DOCUMENTS ANALYZED	295
APPENDIX B: POSTER AND RECRUITMENT LETTER	297
FIRST STUDY FLYER.....	298
SECOND STUDY FLYER.....	299
RECRUITMENT LETTER FOR INTERNATIONALLY EDUCATED NURSES	300
RECRUITMENT LETTER FOR POLICY STAKEHOLDERS	301
APPENDIX C: CONSENT FORMS	302
CONSENT FORM: INTERNATIONALLY EDUCATED NURSES	303
CONSENT FORM: STAKEHOLDERS	306
APPENDIX D: DEMOGRAPHIC PROFILE QUESTIONS AND DATA.....	309
DEMOGRAPHIC PROFILE	310
DEMOGRAPHIC PROFILE COMPLETE DATA.....	312
DEMOGRAPHIC DATA SUMMARY.....	313

APPENDIX E: INTERVIEW QUESTIONS	314
INTERVIEW QUESTIONS FOR CURRENT LIVE-IN CAREGIVERS	315
INTERVIEW QUESTIONS FOR PREVIOUS LIVE-IN CAREGIVERS	317
INTERVIEW QUESTIONS FOR RECRUITERS	319
INTERVIEW QUESTIONS FOR SUPPORT AND ADVOCACY GROUPS (INCLUDING NURSING EDUCATORS)	320
INTERVIEW QUESTIONS FOR POLICY MAKERS (NURSING AND IMMIGRATION).....	321
APPENDIX F: RESEARCH REPORT	322

CHAPTER 1: INTRODUCTION AND BACKGROUND

An increasing proportion of the earth's population – 3.1 percent, or 214 million people – are migrants. Nearly half of these migrants are women. Of such women, an increasing number migrate, not to reunite with their families but to seek jobs far from them. For many, these jobs are to care for the young, the elderly, the sick, or the disabled of the First World. Thus, many maids, nannies, eldercare workers, nurse's aides, nurses, and doctors leave their families and communities in the weak economies of the South to provide care to children and communities in the strong economies of the North. (Hochschild, 2013, p.147).

INTRODUCTION

This dissertation explores the migration of Philippine educated nurses to Ontario through the Live-in Caregiver Program, a Temporary Foreign Worker Program. Temporary foreign workers represent a significant portion of migrants to Canada. In 2012, 213,573 temporary foreign workers gained entry to Canada – almost as many as the number of permanent residents, which is 257,887 (Citizenship and Immigration Canada [CIC] 2013a). Moreover, the number of temporary foreign workers in Canada continues to increase considerably yearly. While 109,667 temporary foreign workers were present in Canada on December 1, 2003, the number had increased to 199,051 workers by December 1, 2007, and 338,221 workers by December 1, 2012 – an increase of more than 300 percent over the decade (CIC, 2013a). The rising numbers of temporary foreign workers in Canada is a response to the shift from a traditional supply driven national immigration policy to one that is based on specific labour market demand (Lowe, 2010; Nelson, 2013). Under the supply driven policy, immigrants are selected based on points earned on certain applicant characteristics such as age, experience, and education; while with a demand

driven policy, selection is based on meeting current, specific employer and economic needs. Temporary foreign worker programs are seen as desirable from a policy perspective as they allow the Canadian government to respond to short-term demands to meet economic and employer needs (Lowe, 2010).

The Temporary Foreign Worker Program category in Canada includes individuals who migrate through the Live-in Caregiver Program, the Low Skilled Worker Program, the Seasonal Agricultural Worker Program, as well as those who migrate as skilled workers. There are limited pathways for temporary foreign workers to become permanent residents in Canada. The creation of a two-step migration pathway (Hawthorne, 2010) for skilled temporary foreign workers through the Canadian Experience Class, as well as for “low-skilled” workers through the Live-in Caregiver Program, ensures that migrants come to Canada with confirmed employment and can transition to permanent resident status after a period of time in Canada. In this way, two-step migration is meant to fulfil both short-term and long-term economic needs.

Created in 1992, the Live-in Caregiver Program is unique in that it allows individuals to achieve permanent resident status after a minimum of 22 months and a maximum of four years of work in Canada. Live-in caregivers must provide care to the elderly, the sick, children, and the disabled, while living in the client’s home for a minimum of 22 months (CIC, 2013a). In Canada, the Live-in Caregiver Program is the only immigration route that enables “low-skilled” workers to transition to permanent residency after a period of work. Internationally, the program is distinctive as it is the only specific program in existence in any country that allows domestic workers to gain citizenship. In spite of the strengths of the Live-in Caregiver Program, there has been growing discussion questioning the administration of the program (Mas, 2013). As of August 2013, the processing time for live-in caregiver applications was 38 months (CIC, 2013b).

Moreover, poor treatment and even abuse of some live-in caregivers has been documented (Pratt, 1999; Spitzer, 2009; Zaman, 2006). The issues of maltreatment and long processing time have led to widespread agreement among policy stakeholders that reform of the Live-in Caregiver Program is needed (Mas, 2013).

To respond to the issue of maltreatment, in 2009, Citizenship and Immigration Canada (2009a) announced measures that required employers to pay all travel and recruitment fees of live-in caregivers, as well as complete an employment contract prior to recruitment. In the same year, further changes were announced: first, the elimination of a second medical when applying for permanent resident status; second, an increase in time to complete the work requirement from three years to four years; and third, the creation of a dedicated live-in caregiver hotline. Since the implementation of these 2009 changes that transferred the cost of recruitment to employers, there has been a decline in the numbers of live-in caregivers admitted to Canada – a 52.6 percent decrease, from 11,867 in 2008 to 6,242 in 2012 (CIC, 2013a).

Furthermore, in 2011, to address the issue of long processing times for permanent resident applications, Citizenship and Immigration Canada (2011a) announced improvements in the processing of open work permits. An open work permit allows live-in caregivers to work in other jobs while their permanent resident applications are being processed. Following this change in December 2011, there has arisen a shortage of live-in caregivers. Recruiters blame the increasing cost to employers and the granting of open work permits to over 14,000 live-in caregivers in December 2011 as the causes of this shortage (Keung, 2012). The shortage has led to increasing competition for live-in caregivers, and according to Keung (2012), “nanny poaching”.

One issue that has received attention from immigration policy makers (especially the Minister of Citizenship and Immigration), but less so from the general public, is that of retention of live-in caregivers. As the previous Minister of Citizenship and Immigration, the Honorable Jason Kenney¹ noted, “the program constantly cycles through people, so as soon as people get permanent residency they leave live-in caregiver work” (Mas, 2013). This raises the question as to whether the program is adequately meeting labour market needs. The tendency for live-in caregivers to cease working as live-in caregivers after they satisfy the program’s requirements may be due to the fact that some of these workers are in fact educated professionals, including nurses, with career aspirations (Kelly, Astorga-Garcia, Esguerra, and Community Alliance for Social Justice, 2009).

While the education prerequisite for the Live-in Caregiver Program is high school completion, evidence suggests that some qualified nurses migrate to Canada through the Live-in Caregiver Program (Zaman, 2006). Some of the skills that nurses possess are seen as well suited to live-in caregiver work and fit the areas of study for prospective live-in caregivers which are “early childhood education, geriatric care, pediatric nursing or first aid” (CIC, 2009b). Overwhelmingly, nurses who migrate through the Live-in Caregiver Program are from the Philippines (Philippine Women Centre, 2001; Zaman, 2006), and more than 50 percent settle in Ontario (CIC, 2013a).

Nurses who migrate through the Live-in Caregiver Program must become permanent residents to register as nurses in Ontario, and the application processing time for permanent residency (which is required for nursing registration) is currently longer than three years (Mas,

¹ Minister Jason Kenney was the Minister of Citizenship, Immigration and Multiculturalism from October 30, 2008 to July 15, 2013.

2013). In January 2013, the College of Nurses of Ontario (CNO)² changed its entry to practice requirement such that all new registrants must demonstrate that they have worked as a nurse within the previous three years rather than five years. Given this timeline, nurses who migrate through the Live-in Caregiver Program will likely not be able to demonstrate they have the requisite three years of recent safe nursing practice. While this College of Nurses of Ontario policy change is specific to the province, recent changes across Canada, including the creation of the Canadian Council of Registered Nurse Regulators (Canadian Council of Registered Nurse Regulators, 2013) and the Labour Mobility Act (Nelson, Verma, McGillis-Hall, Gastaldo, Janjua, 2011), have meant increasing inter-connectedness and harmonization across Canadian provinces. By easing mobility across Canada, nursing policy changes in one area has wider consequences (Nelson, 2013). Notwithstanding the overt conflict between immigration and nursing policy, there remains a shortage of nurses in Canada (Tomblin-Murphy et al., 2009), especially in areas of specialty practice such as critical care nursing and operating room nursing – areas that often require experienced nurses (MacMillan, 2013).

The topic of this dissertation is situated in this shifting policy context (both immigration and nursing policy). It also pays attention to issues of gender, race and class by utilizing the transnational feminist concept of global care chains. The choice of this theoretical focus derives from the first motivation for this study, which was to explore the experience of the “subaltern” in nursing, as informed by the work of feminist postcolonial theorist Gayatri Spivak. According to Spivak (2005), “subalternity is where the social lines of mobility do not permit the formation of a recognizable basis of action” (p. 476). Spivak’s idea of the subaltern led me to an interest in the

² The College of Nurses of Ontario is the nursing regulatory body in Ontario. Its mission is to regulate nursing in the public interest (College of Nurses of Ontario, 2012a).

most marginalized group in the nursing profession, and their challenges in gaining entry to the nursing workforce. Among educated nurses, those who enter Canada as live-in caregivers face the most significant marginalization to nursing workforce integration in Ontario (Baumann, Blythe, Rheaume, & McIntosh, 2006). This study combines a critical perspective derived from transnational feminist theory (specifically the concept of global care chains) with a policy-related case study design to explore the migration of Philippine educated nurses to Ontario through the Live-in Caregiver Program.

The first chapter presents background on Canada's immigration policy (including the Temporary Foreign Worker Program), the Live-in Caregiver Program, the nursing workforce in Canada and, lastly, current national and provincial initiatives. Chapter 2 consists of a literature review that includes studies on labour market outcomes for immigrants in Canada, integration of internationally educated nurses in Canada, global nurse migration, global domestic worker migration, and live-in caregivers in Canada (including nurses who migrate through the Live-in Caregiver Program). The preliminary problem and research questions are also presented in this second chapter. Chapter 3 provides an outline of the concept of global care chains as a theoretical framework used to address the research problem. Based on the transnational feminist concept of global care chains, the research problem is further refined and restated at the end of this third chapter. Chapter 4 presents the study methodology which utilizes a typical single case study design with discourse analysis. Chapter 5 presents a reflexive analysis of the researcher's stance, including issues of positionality and social difference in the data collection process.

The results of the study are presented in chapters 6, 7 and 8. Chapter 6 presents the migration path of the live-in caregivers interviewed for this study. In a quest to gain citizenship for family members, migration commonly involves a two-step path from the Philippines to the

Middle East and then to Canada. Chapter 7 presents their experiences in Canada, including that of partial citizenship and non-belonging, the employer/employee relationship, the pain of family separation, and the contradictions in class mobility. Chapter 8 draws on data from interviews with stakeholders and live-in caregivers to explore issues of rights and obligations as they relate to the migration of nurses through this program. Lastly, chapter 9 presents further discussion, implications, and conclusions.

CANADIAN IMMIGRATION

Introduction to Canada's Immigration System

The Canadian Immigration and Refugee Act states that the first objective of Canadian immigration and refugee policy is “to permit Canada to pursue the maximum social, cultural and economic benefits of immigration” (Government of Canada, 2001, 3.1.a). Immigration policy in Canada balances three main goals: “to support the development of a strong and prosperous Canadian economy; to see that families are reunited in Canada; and to provide a safe haven for refugees and people in need of protection” (CIC, 2009c). In line with these goals, there are three major permanent immigration categories in Canada: the family class, the refugee class, and the economic class (CIC, 2010). The family class enables permanent residents or citizens of Canada to sponsor members of their family to be reunited with them in Canada. The refugee class allows for the admission of individuals who are in need of protection from persecution, torture, punishment, cruelty or a risk to their life. The economic class enables the entry of individuals with capital to benefit Canada's economy.

Immigrants in the permanent residence economic class can migrate through the Provincial Nominee Program, the Canadian Experience Class, the Federal Skilled Worker

Program, and the Business Class (CIC, 2010). The Provincial Nominee Program allows provinces to nominate individuals for permanent resident status. The Federal Skilled Worker Program allows individuals with skills and experiences that are in demand in Canada or individuals with arranged employment to migrate permanently to Canada. To qualify to migrate to Canada as a skilled worker, individuals must score at least 67 points in six selection factors: education, proficiency in English and/or French, experience, age, arranged employment in Canada, and adaptability. In addition, the prospective immigrant must demonstrate proof of funds³ and a minimum of one year experience in an occupation that is listed by the Citizenship and Immigration Canada as experiencing a shortage of workers in Canada, or have arranged employment. Furthermore, beginning in May 2013, all applicants to the Federal Skilled Worker Program must complete an Educational Credential Assessment by an agency that is approved by Citizenship and Immigration Canada and must demonstrate a minimum level of language requirement (CIC, 2013c). The Business Class allows entrepreneurs, self-employed individuals, and investors who can invest more than \$800,000 (Canadian) and/or own and manage a business in Canada with the minimum required net worth to migrate to Canada permanently (CIC, 2010). The Canadian Experience Class allows temporary foreign workers with experience in Canada, or international students who have graduated from Canadian educational institutions, to become permanent residents. Therefore, the Canadian Experience Class is the second step in a two-step migration process (Hawthorne, 2010) for individuals in the Temporary Foreign Worker Program (excluding live-in caregivers, seasonal agricultural workers, or low skilled workers) and international students to become permanent residents in Canada.

³ Proof of funds for individuals migrating through the Federal Skilled Worker is \$11,115 for a family of one, \$13,837 for a family of two, and \$17,011 for a family of three (CIC, 2013e).

In addition to the permanent immigration categories, individuals can also migrate temporarily to Canada. The temporary foreign worker immigration streams include individuals who migrate through the Live-in Caregiver Program, the Seasonal Agricultural Worker Program, the Low Skilled Pilot Program, International Student Program, and other individuals who apply to migrate temporarily to Canada (CIC, 2010). The Seasonal Agricultural Program allows individuals from Mexico and Caribbean countries to migrate temporarily to Canada during planting and harvesting season to work in the farming industry. The Low Skilled Pilot Worker Project is a rapidly growing temporary immigration stream that allows individuals to migrate for a period of two years to work in occupations that require a maximum of high school education or two years on the job training (Human Resource and Skills Development Canada, 2013). The International Student Program allows individuals to migrate temporarily to Canada for educational purposes. Also, individuals can migrate temporarily to Canada (in occupations with a shortage) to work as skilled workers (Human Resource and Skills Development Canada, 2013). After the completion of the International Student Program or Temporary Foreign Skilled Worker Program, qualified individuals can apply to the Canadian Experience Class to become permanent residents in Canada. However, individuals in occupations requiring low skills (the Live-in Caregiver Program, the Seasonal Agricultural Worker Program, and the Low Skilled Program) cannot apply to become permanent residents through the Canadian Experience Class.

In the year 2011, Canada had the second highest percentage of immigrants at 20.6 percent (Statistics Canada, 2013). Australia had the highest percentage of immigrants (26.8%), while Germany (13%) and the United States (12.9%) had the third and fourth highest percentage of immigrants, respectively. In 2012, Canada welcomed 257,887 permanent residents and 213,573 temporary foreign workers (CIC, 2013a). Asia is the predominant source region of permanent

immigrants to Canada, with Philippines, China, and India being the top three source countries (CIC, 2012).

Ontario is the destination province for the majority of immigrants to Canada. According to the National Household Survey, of the 6.8 million foreign-born individuals who lived in Canada in 2011, 53.3 percent (3,611,400 immigrants) lived in Ontario (Statistics Canada, 2013). Moreover, in that same year, Ontario received 43.1 percent of immigrants who arrived in Canada, or just over 501,000 immigrants. By the year 2031, Statistics Canada (2010) projects that 63 percent of Toronto's population will be immigrants and 78 percent of Toronto's population will be immigrants or children born of immigrants. Based on these projections, in the year 2031, immigrants from South Asian countries will represent 24 percent of Toronto's population, up from 14 percent (Statistics Canada, 2010).

A significant number of migrants come to work in Canada under the Temporary Foreign Workers Program. In total, there were 338,189 temporary foreign workers present in Canada as of December 1, 2012. Moreover, the migration of this group of migrants to Canada demonstrates an increasing trend (Nakache & Kinoshita, 2010). Between 2003 and 2012, the number of temporary foreign workers present in Canada increased by more than 300 percent (CIC, 2013a). The trend toward increase in this migrant population is congruent with the experience of several OECD (Organization for Economic Co-operation and Development) nations among which the number of temporary foreign workers increased by 7 percent (approximately 1.5 million people) between 2003 and 2004 (Hawthorne, 2008). As of December 1st of 2011, the Philippines remained the top source country of temporary foreign workers to Canada, sending 45,450 workers of a total of 300,211 (CIC, 2012). A significant number of immigrants from the Philippines migrate to Canada through the Live-in Caregiver Program (Kelly, 2006).

The growing number of temporary foreign workers in Canada deserves attention. A significant percentage of temporary foreign workers settle in Ontario, in consonant with the general migration pattern in Canada. Of significance is the high representation of Filipino migrants through the Temporary Foreign Worker Program. A significant number of Filipinos in Canada migrate through the Live-in Caregiver Program.

LIVE-IN CAREGIVER PROGRAM

History of the Live-in Caregiver Program in Canada

The Live-in Caregiver Program is a special immigration stream for individuals to migrate temporarily to Canada to work as domestic workers. Historically, the Live-in Caregiver Program is driven by the lack of a national child care and elder care system as well as the increasing participation of women in the workforce (Arat-Koc, 1997; Bourgeault, Atanackovic, LeBrun, Parpia, Rashid, & Winkup, 2010). First to mitigate the problem of a paucity of domestic workers in the late nineteenth and early twentieth centuries (1888 – 1920s), white British domestic workers were chosen, with particular interest to their future role as mothers and wives (Cunningham-Armacost, 1995). Due to the inability of the Canadian government to fulfil the objective of increasing the population of Canada and meeting Canada's labour market needs through an exclusively British source of immigration, immigrants were also sought from Scandinavia as well as Central and Eastern Europe (Arat-Koc, 1997). In fact, in the early twentieth century, Scandinavian countries (especially Finland) were the preferred source of domestic workers to Canada. In 1925, the Canadian federal government signed an agreement with the Canadian Pacific Railway and the Canadian Railway which authorized these companies to recruit and place domestic workers. This agreement resulted in an increase in the number of

domestics from Central and Eastern Europe. Post-World War Two, Canada continued to suffer from a shortage of domestic workers, which resulted in Canada's opening its doors to Italian domestics in the 1950s. However, ethnocentric values dominant at this time made the migration of Italians as domestic workers short-lived (Arat-Koc, 1997, p. 72).

Women of colour have been a continuous source of domestic workers to Canada, beginning in the days of slavery (Arat-Koc, 1997). An experiment was undertaken in Quebec in 1911 to admit 100 French-speaking domestic workers from the Caribbean, particularly Guadeloupe (Cunningham-Armacost, 1995). This was brief due to the recession of 1913-1915 and due to stereotypical views towards these migrants as being immoral (Arat-Koc, 1997). However, in 1955, Canada entered into a domestic scheme with Jamaica and Barbados, as it had exhausted the possibilities of securing domestic workers from Europe, and simultaneously, was facing mounting pressure from Caribbean governments. Domestic workers from the Caribbean at this time had to be unmarried, between the ages of 21 and 35, have an assigned employer, and be willing to perform domestic work. This program continued bringing in over-qualified domestic workers from the Caribbean. Calliste (1993) notes that Caribbean women admitted at this time were admitted only as "cases of exceptional merit" (p. 85), and female domestics from third world countries (mainly from the Caribbean) experienced great racial barriers (Bakan & Stasiulis, 1997; Calliste, 1993). Calliste (1993) attributed this to the stereotype that "blacks were stigmatized as mentally, physically, and socially inferior and as a permanent social problem in Canada" (p. 89). Under the Immigration Act (1910 -1967), the Canadian government had the legal power to prohibit entry of immigrants belonging to "any race deemed unsuited to the climate or requirement of Canada" (Arat-Koc, 1997, p. 74). This was based on the assumption that non Caucasians were not biologically capable of adjusting to the Canadian climate (Calliste,

1993). The introduction of the point system in 1967 helped to decrease these explicitly racist criteria by emphasizing labour market requirements (Arat-Koc, 1997).

Also in the 1960s, in response to a compromise to resolve the previous Canadian government's non-admission of Filipinos to Canada and the reciprocal sanction by the Philippine government against the entry of Canadian immigrants to the Philippines, increasing numbers of immigrants from the Philippines were allowed by the Canadian government to migrate to Canada (Daenzer, 1997). By 1989, 50 percent of temporary domestic workers originated from the Philippines. The Foreign Domestic Worker Program was created in 1981 to provide a cheap and efficient pool of migrant workers (mainly third world women) to serve the childcare and elder care needs of Canadian families. According to Bakan and Stasiulis (1997), domestic workers have experienced declining privileges of citizenship over the years since 1981. For instance, domestic workers who migrated before 1981 were not required to live in their client's home, thus retaining their right to choice of domicile. Daenzer (1997) notes that government reports during this time indicated that domestic workers and the occupation of domestic work was severely undervalued. A mandatory live-in requirement was instituted in 1991 with a change from the Foreign Domestic Worker Program to the Live-in Caregiver Program, based on the argument that jobs for live-out service can be readily filled by workers in the Canadian labour market.

Current Live-in Caregiver Program

The current Live-in Caregiver Program is a Temporary Foreign Worker Program that allows individuals to migrate temporarily to Canada to care for children, the elderly, or the disabled, while living in the client's home. To qualify to migrate through the Live-in Caregiver Program, potential live-in caregivers must have the equivalent of a high school education (12

years education). In addition, applicants must receive either six months full-time classroom training or twelve months' work experience in a field or occupation in which they will be practising as live-in caregivers. According to Citizenship and Immigration Canada (2009b), "areas of study could be early childhood education, geriatric care, pediatric nursing or first aid". The entry of live-in caregivers to Canada reached its peak in 2007 when 12,952 temporary residents migrated to Canada. Recently, there has been a decline in admission under the Live-in Caregiver Program to 5,882 new entries in 2011 (CIC, 2012).

On December 12, 2009, the Minister of Citizenship and Immigration Canada announced significant changes to the Live-in Caregiver Program (CIC, 2009a). Formerly, live-in caregivers were given a three-year plus three-month work permit, after which they had to apply for a new work permit. In addition, before April 1, 2010, live-in caregivers could apply for permanent residency after a total of 24 months of work in Canada, completed within the first three years in Canada. Beginning in April 1, 2010, live-in caregivers are eligible to apply for permanent residency in Canada after 24 months of authorized full-time employment or a total of 3,900 hours of authorized full-time employment (within a minimum of 22 months). Citizenship and Immigration Canada also extended the time live-in caregivers are allowed to complete the employment requirement for permanent residency to four years. Other changes to the Live-in Caregiver Program include: requiring employers to enroll and pay the costs of health insurance, provincial workplace safety insurance, recruitment cost and third party fees, as well as transportation cost to Canada (all at no cost to the live-in caregiver). It became mandatory for live-in caregivers and employers to have an employment contract with clauses that address employer benefits (including paid transportation, health insurance, workplace safety insurance, and reimbursement of recruitment costs), accommodation, duties, hours of work (including

overtime hours), wages, holiday and sick leave entitlements, and terms of termination or resignation. Furthermore, in December 2011, Citizenship and Immigration Canada announced the granting of open work permits immediately after live-in caregivers complete the program requirements (CIC, 2011a). This will allow caregivers to live out or work in another job while waiting to become a permanent resident in Canada.

While some of these policy shifts represent positive significant changes to the Live-in Caregiver Program, there still exist several restrictions for individuals migrating as live-in caregivers to Canada. For instance, live-in caregivers are not allowed to take credit courses of more than six months duration without a study permit from Citizenship and Immigration Canada. To receive a study permit, the live-in caregiver must present a letter from the educational institution indicating that the course of study will be completed on a part-time basis as well as provide a \$125 application processing fee to Citizenship and Immigration Canada (Brigham, & Bernardino, 2003). Any courses they take must be related to their work as a live-in caregiver. Moreover, in order to remain in Canada, live-in caregivers must have an employment contract with an employer (CIC, 2009a). This stipulation is mandatory in order to qualify for a work permit as a live-in caregiver. As of September 2013, renewal of a work permit with a previous employer takes up to 28 days for online applications and 65 days for paper applications (CIC, 2013b). Renewal of a work permit with a new employer takes up to 28 days for online applications and 55 days for paper applications.

In summary, the Live-in Caregiver Program has evolved from its precursor, the Foreign Domestic Worker Program, with more restrictive regulations, including the requirement to live in the client's home. However, in recent years, there have been policy changes targeted at addressing some of the short comings of the program. This recent changes have not sufficiently

addressed its gaps. For instance, the restriction on taking courses during the program may restrict the long term professional integration of these individuals, some of whom are educated nurses from the Philippines (Philippine Women Centre, 2001). The next section provides a background on the nursing workforce in Canada.

NURSING WORKFORCE

Canadian Nursing Workforce

Internationally educated nurses are a unique group of immigrants in Canada. Although there are no available comprehensive data on the total number of internationally educated nurses who migrate to Canada every year, Hawthorne's (2007) analysis of Statistics Canada immigration data indicates that from 2001 to 2003, the number of internationally educated nurses who arrived in Canada as principal applicants was 1,167. Close to two-thirds of these nurses (62%) arrived in Canada under the family or humanitarian category, while over a third (38%) arrived as economic immigrants. In 2009, 19.1 percent of females in the Federal Skilled Worker Program who were issued visas to migrate to Canada were Registered Nurses. Also, by January 2011, Canada had already reached its maximum quota of 1,000 Registered Nurse applicants to immigrate through the Federal Skilled Worker Program for the period July 2010 to June 2011 (CIC, 2011b). This number of Registered Nurses is in addition to the individuals who applied as Practical Nurses and nurses who applied as secondary applicants and family class applicants. The most recent list of occupations in demand for the Federal Skilled Worker Program does not include nurses, neither Registered Nurses nor Registered Practical Nurses (CIC, 2013d). However, nurses can still migrate to Canada as skilled workers through the Provincial Nominee Program.

Approximately 23 percent of nurses in Canada are foreign-born (Hawthorne, 2008); however, many of them received their nursing education in Canada. In fact, according to the Canadian Institute of Health Information (CIHI, 2013), of the Canadian regulated nursing workforce, only 8 percent were educated outside Canada. The regulated nursing workforce in Canada consists of Registered Nurses (RN), Registered or Licensed Practical Nurses (RPN), Registered Psychiatric Nurses⁴ and Nurse Practitioners. Registered Nurses (RN) are the predominant group among the regulated nursing workforce in Canada.

In 2011, internationally educated nurses comprise 8.6 percent of the registered nurse workforce in Canada. In total, 32.7 percent of these RNs were educated in the Philippines, while 15.2 percent were educated in the United Kingdom (CIHI, 2013). In 2009, the majority of internationally educated nurses were resident in Ontario (10,850 or 49.3%), British Columbia (5,066 or 23%), Alberta (2,924 or 13.3%) and Quebec (1,683 or 7.6%) (Canadian Institute of Health Information, CIHI, 2010). British Columbia (16.4%) had the highest percentage of internationally educated nurses in its registered nurse workforce, followed by Ontario (11.6%) and Alberta (10%). The numbers of registered or licensed practical nurses in Canada who are internationally educated nurses are much smaller at 2.3 percent or 1,805.

Nursing Workforce in Ontario

To become a Registered Nurse in Ontario, internationally educated nurses must apply to the College of Nurses of Ontario. Then, internationally educated nurses receive a letter of direction from the College which states their eligibility or ineligibility to become a nurse in

⁴ Registered Psychiatric Nurses exist only in four western provinces – British Columbia, Alberta, Saskatchewan and Manitoba.

Ontario, and if eligible, the steps to become registered to practice (Baumann et al., 2006). The letter of direction may also state what bridging or upgrading programs that internationally educated nurses need to complete before becoming a Registered Nurse (RN) or Registered Practical Nurse (RPN) in Ontario. Finally, internationally educated nurses must pass the national registration examination to become registered. In short, to complete the application process for licensure in Ontario, internationally educated nurses must first meet seven requirements: (1) complete an acceptable registered nurse or registered practical nurse educational program; (2) pass the Canadian registered nurse or registered practical nurse examination; (3) pass the jurisprudence examination; (4) provide evidence of recent safe nursing practice; (5) demonstrate written and spoken language fluency in English or French; (6) provide proof of Canadian citizenship, permanent resident, or authorization under the Immigration and Refugee Protection Act (Canada) to engage in the practice of nursing; and (7) complete a declaration of registration requirement (CNO, 2013a).

To register as a Registered Nurse (RN) in Ontario, the minimum education is the equivalent of a four-year bachelor's degree, while the minimum of the equivalent of two-year diploma is required to register as a Registered Practical Nurse (RPN) in Ontario (CNO, 2013a). Beginning in January 2013, to provide evidence of recent, safe nursing practice, the internationally educated nurse must prove they have provided same nursing practice within the last three years (which can include education and/or experience). Prior to this date, they had to provide a reference from their most recent employer(s) verifying that they have worked for 1,125 hours in nursing within the past five years. If this requirement is not met, internationally educated nurses must complete additional education. If all requirements are met, internationally educated nurses can write the Canadian Registered Nursing Exam or the Canadian Practical

Nursing Registration Exam, both of which are offered multiple times over a year. However, applicants have a maximum of three opportunities over an unlimited time span to complete these exams, and the exam is not offered outside Canada.

Disparities exist in the ability of internationally educated nurses to become registered to practise in Canada, as compared to their Canadian-educated counterparts. For instance, in 2012, the College of Nurses of Ontario received 10,458 new applications from Ontario trained nurses, of which 7,736 applicants (74%) became members (Office of the Fairness Commissioner, 2013). In comparison, the percentage of applications from internationally educated nurses (except the United States) who were successful in becoming registered to practise was much lower at 32 percent (1,761 of 5,517). This disparity in the ability of internationally educated nurses to become registered in Ontario can be explained by the examination success rate. In 2012, the pass rate for Ontario educated nurses who wrote the nursing registration exam for the first time was 80.7 percent while the rate for exam writers from outside Ontario (including internationally educated nurses) was 35.3 percent (CNO, 2013b). The inability of internationally educated nurses to become licensed to practise in Ontario has serious implications for the loss of nursing human capital at a time when there is a national and global shortage of nurses (Tomblin-Murphy et al., 2009; World Health Organization, 2010a).

SUMMARY OF BACKGROUND

Canada is becoming more reliant on temporary foreign workers, including live-in caregivers (Nakache & Kinoshita, 2010). The Philippines remains the top source country of temporary foreign workers in Canada (CIC, 2012), with the majority of individuals from the Philippines migrating through the Live-in Caregiver Program (Kelly, 2006). The Live-in

Caregiver Program is an immigration stream that allows qualified individuals to migrate to Canada to provide care to children, the sick, the elderly, and the disabled. The website of Citizenship and Immigration Canada (2009b) states that live-in caregivers must have nursing-related experience or education, including pediatric nursing and elder care, to migrate to Canada.

On migration to Canada, internationally educated nurses must meet seven requirements to become licensed to practise in Canada. Inability to meet any of these requirements may prevent internationally educated nurses from practising as nurses in Canada. Furthermore, data from the College of Nurses of Ontario shows that 32 percent of internationally educated nurses who applied to register as nurses in the year 2012 were unsuccessful that year (Office of the Fairness Commissioner, 2013). This trend alludes to the barriers to integration of internationally educated nurses, the majority of whom are immigrant women from the Philippines, at a time of global nursing shortage.

Based on evidence provided so far, the demographic shifts in migration to Canada, and the policies of the Temporary Foreign Worker Program, it is important to explore the experiences of nurses who work as live-in caregivers in Canada. This is especially crucial because of their vulnerability to exploitation and the increased susceptibility to deskilling due to the policy of the Live-in Caregiver Program, including the significant period of separation from clinical nursing practice. Furthermore, the College of Nurses of Ontario recently implemented changes to its entry to practice requirement that may present added challenges to this group of workers. This topic is of great relevance to nursing to address inequities within the nursing profession by providing an avenue for this group of nurses to have a voice, in line with Gayatri Spivak's (2005) idea on creating channels of agency for the subalterns.

CHAPTER 2: LITERATURE REVIEW

Chapter 1 provides a background on the study including the policies of the Live-in Caregiver Program and nursing policy in Ontario. Chapter 2 presents a review on the literature including immigrant labour market experience, nurse migration, global domestic worker migration, and live-in caregiver migration to Canada. At the core of my literature review is the sparse research on nurses who migrate to Canada (specifically the province of British Columbia) through the Live-in Caregiver Program. The final section of the chapter draws from the literature that has explored the Canadian Temporary Foreign Worker Program.

IMMIGRANTS IN CANADA

Immigrants' Labour Market Experience

In recent years, Canada has prioritized economic migration to address the needs of the knowledge economy, by selecting migrants based on economic need (Hawthorne, 2008). Thus, it is unsurprising that in 2007, landed immigrants between the ages of 25 and 54 were more likely to have a university degree than the Canadian-born (37% versus 22%; Gilmore & Le Petit, 2008). Despite the fact that immigrants are more educated on average, they are less likely to participate in the labour force in their profession (Hawthorne, 2008). Of immigrants who arrived in Canada between 2001 and 2006, those from South Africa, Australia, and the United States were the most likely to find work in their profession. Moreover, in 2008, the unemployment rate of immigrants (6.8%) was much higher than that of the Canadian-born (4.6%; Yssaad, 2012).

Immigrants from the Philippines have the highest employment rate (and lowest unemployment rate) of all immigrants (Yssaad, 2012). In fact, in 2011, the employment rate of immigrants from the Philippines was higher than that of the Canadian-born (85.6% versus 82.9%, respectively). According to Yssaad (2012), one explanation for the high employment rate

among Philippine immigrants is that most Philippine women migrate to Canada through the Live-in Caregiver Program and already have pre-arranged employment pre-migration. Although immigrants from the Philippines are more likely than other immigrants to be in the labour force, they are least likely to find work in their profession (Hawthorne, 2008). According to Houle & Yssaad (2010) Filipino immigrants have the poorest credential recognition rate of all immigrants to Canada. For instance, 58 percent of very recent immigrants who completed their education in the Philippines are over-educated for their job as compared to 41 percent of the Canadian-born population (Ewoudou, 2011).

Gilmore and Le Petit's (2008) analysis of the Canadian labour market in 2007 revealed that the ability of immigrants to find employment is affected by recognition of their foreign credentials; level of educational attainment; degree and length of experience abroad and within Canada; differences in quality of education in source countries; language barriers and related difficulties; varying strength of social networks; and knowledge of and information about the Canadian labour market. Similarly, Reitz (2007) stated that immigrant employment success in Canada is dependent on: 1) immigration policy in Canada and the settlement patterns of immigrants; 2) entry effects and assimilation over time (including the region of settlement); 3) the lower labour market value of immigrants' qualification (including the quality of educational preparation); and 4) the racial, national and/or ethnic origin of immigrants (as well as discrimination based on such backgrounds).

Given the poorer economic outcomes of permanent immigrants, Canada has increasingly relied on temporary foreign workers to ensure it better meets employer needs (Lowe, 2010). Sweetman and Warman (2010) suggest that while there may be more economic benefit from the Temporary Foreign Worker Program in Canada, these benefits come with some risk of exploiting

workers who have limited rights, and also risk to the Canadian population, through greater competition for jobs which exerts downward pressure on wages. Despite these risks, temporary foreign workers achieve great economic success when compared to recent immigrants. For instance, Sweetman (2010) found that temporary foreign workers (age 30 to 64) living in Canada for less than four years, have a higher rate of return for their education and experience versus new immigrants in the skilled category. Critically, these benefits become limited when temporary foreign workers are unable to settle or integrate in Canada (Nakache & Kinoshita, 2010; Reitz, 2010).

Immigrant Women's Labour Market Experience

Immigrant women represent 20.3 percent of Canada's female population (Chui, 2011). The majority of immigrant women in Canada migrate through the economic or family categories. Major destination cities of immigrant women include Toronto, Vancouver, and Montreal. In fact, 38 percent of immigrant women migrate to Toronto, where around half the female population is immigrant. Congruent with the experience of male immigrants, immigrant women experience higher rates of poverty than Canadian-born peers due to their inability to find employment (Picot, Hou, & Coulombe, 2008). Also, female immigrants have a higher poverty rate than male immigrants. The poorer labour market outcomes of immigrant women versus immigrant men is further compounded by the fact that immigrant women have lower credential recognition rates than immigrant men (Houle & Yssaad, 2010). Given their poor labour market outcomes, immigrant women are twice as likely to be low income earners as compared to Canadian-born women (Chui, 2011).

Gaye and Jha (2011) found this trend in immigrant women labour market outcomes to be consistent across 19 countries in the Luxembourg Income Survey. Their analysis determined that immigrant women are generally found in lower paying jobs. Even in countries where female migrants are more highly educated than male migrants, female migrants fare less well economically than their male counterparts. The lower employment success rate for female immigrants is also evident in Canadian data. According to the 2006 Canadian Labour Force Survey, the unemployment rate of Canadian-born men was 5.2 percent and 4.6 percent for Canadian-born women, whereas the unemployment rate of recent (less than 5 years) immigrant men was 10.3 percent and the unemployment rate for recent immigrant women was 13.0 percent (Zietsma, 2007).

Rasouli (2010) conducted a survey of 202 immigrant women to investigate the factors that influenced their career adjustment in Canada. She found that education in the host country, number of years living in Canada, and accreditation were significant predictors for immigrant women's career adjustment in Canada. However, Ng and Hongxia (2010) note that immigrant women still experience challenges in integrating into the professional workforce, even after completing educational programs in Canada. In two to three hour life history interviews with 21 Chinese immigrant women who came to Canada (largely Toronto) as skilled workers between 1998 and 2005, Ng and Hongxia (2010) found that the women experienced great challenges obtaining employment in their field in Canada. Of the women interviewed, sixteen attended an occupation-specific training program in Canada. Only two of the women interviewed found employment in their pre-migration occupation. Most of the women interviewed changed their profession to take a job in a female-dominated profession and entered at junior levels.

George and Chaze (2009) postulated that social capital may have a role to play in the successful integration of immigrant women. A survey of 500 South Asian women and in-depth qualitative interviews with 50 South Asian immigrant women on the role of social capital in searching for and gaining employment in Canada found that pre-existing social capital (including those gained prior to migrating to Canada) and self-created social capital after migrating to Canada (including volunteer work) leveraged women's ability to find work in Canada (George & Chaze, 2009). This finding is consistent with that of Bourgeault et al. (2010) who interviewed 75 immigrant women providing elder care and found that most of these women obtained their job through social networks. However, like other women, immigrant women's ability to find paid or unpaid (i.e., volunteer) work is affected by their family responsibilities, including their role as mothers (Statistics Canada, 2006). Immigrant women are more likely to live with family members than immigrant men or Canadian-born women (Chui, 2011). For women who do find work, they are more likely to be concentrated in the lower levels of traditional female-dominated professions, such as the service industry as well as healthcare industry, including nursing (George & Chaze, 2009).

In summary, the literature demonstrates poorer labour market outcomes for immigrants, despite having higher years of education than their Canadian counterpart. Moreover, immigrant women have a poorer labour market outcome than immigrant men. Gender, including ascribed gender roles, has a role to play in the poorer labour market outcome of women. Even after the completion of educational programs, immigrant women experience challenges in gaining entry into the professional workforce. Also, immigrant women are concentrated in nursing related roles, a traditional female dominated profession.

NURSING WORKFORCE / MIGRATION

Canada is experiencing a shortage of nurses in specialty areas and in rural areas (MacMillan, 2013). Several strategies have been proposed for solving the nursing shortage, including decreasing the out-migration of nurses, increasing enrollment in nursing schools (Tomblin-Murphy et al., 2009), and strengthening incentives for Canadian nurses practising in other countries, like the United States, to return to Canada (McGillis Hall, Pink, Jones, Leatt, Gates, & Peterson, 2009). Another strategy that has been proposed is the utilization of internationally educated nurses who are currently residing in Canada (Baumann, et al., 2006; Jeans, Hadley, Green, & Da Prat, 2005).

It is argued that internationally educated nurses represent an underutilized nursing human resource in Ontario (Baumann et al., 2006). In 2012, the predominant countries of internationally educated nurse applicants to the College of Nurses of Ontario included the Philippines (2216), India (2155), and Nigeria (155) (Office of the Fairness Commissioner, 2013). There has been an increasing trend in the number of internationally educated nurse applicants to the College of Nurses of Ontario. For instance, in 2008, 1180 applications were received by the College of Nurses of Ontario from Philippine educated nurses (Office of the Fairness Commissioner, 2009) while in 2012 the College received 2216 applications from Philippine educated nurses (Office of the Fairness Commissioner, 2013).

While the Philippines remains the top source country of applicants to the College of Nurses of Ontario (Office of the Fairness Commissioner, 2013), there has been a decline in the number who become Registered Nurses in Ontario (College of Nurses of Ontario, 2013c). The percentage of internationally educated nurses who are from the Philippines and became licensed to practise as Registered Nurses in Ontario decreased from 33 percent (333) in 2003 to 16.6

percent (107) in 2012 (College of Nurses of Ontario, 2013c). India has taken over the lead as the top source country of new internationally educated Registered Nurses in Ontario at 35.7 percent (230) in 2012. The Philippines still remains the top source country of new internationally educated Registered Practical Nurses in Ontario (College of Nurses of Ontario, 2013c). The number of internationally educated nurses from the Philippines who became registered as Practical Nurses in Ontario increased from 17 (or 30.4%) in the year 2003 to 630 (or 53%) in 2012. In fact, more Philippine educated nurses are becoming registered as Registered Practical Nurses rather than Registered Nurses. Given that nurses in the Philippines complete a baccalaureate degree, the downward trend in the registration of Philippine educated nurses as Registered Nurses in Ontario, coupled with an upward trend in becoming registered as Registered Practical Nurses, signifies downward occupational mobility of nurses from this source country. The struggles of nurses from the Philippines to become registered to practise as nurses in Ontario may be due to barriers to their workforce integration.

Barriers to Workforce Integration of Internationally Educated Nurses

Data from the College of Nurses of Ontario (2005, 2009a) indicates that a significant number of internationally educated nurses do not complete the process of registration to become registered to practise in Canada. Research conducted on the barriers facing internationally educated nurses in Canada suggests that they experience significant barriers to workforce integration. Jeans, Hadley, Green, and Da Prat (2005) conducted 32 focus groups with 212 internationally educated Registered Nurses, Registered Practical Nurse, and Registered Psychiatric Nurses across Canada. They found that internationally educated nurses faced

challenges with information and communication, the assessment process, language, the national examination, cost, and immigration.

Internationally educated nurses lacked sufficient information to make informed decisions about the process of registration (Higginbottom, 2011; Jeans et al., 2005). Internet sites catering to internationally educated nurses often included information that was incomplete, confusing, or written at a level of English that internationally educated nurses had trouble comprehending (Jeans et al., 2005). There were barriers in being able to produce the necessary documents required by the regulatory bodies (Jeans et al., 2005). Once documents were assessed, internationally educated nurses found that their level of education was not accepted as an equivalent to that required to practise in Canada.

Even if applicant were able to produce the necessary documents, they often faced challenges with language or passing the language test (Jeans et al., 2005). Inadequate English language capability made it difficult for internationally educated nurse to pass the national examination required by all Canadian provinces (Blythe, Baumann, Rheaume & McIntosh, 2009; Jeans et. al., 2005). Moreover, the issue of language proficiency extends beyond the ability to become registered to practise in Canada. In a qualitative study of 30 newly (less than three years) registered internationally educated nurses in Ontario, conducted by Tregunno, Campbell, Peters, and Gordon (2009), internationally educated nurses reported difficulties with verbal and non-verbal communication with both patients and colleagues. Baumann et al. (2006) also found that internationally educated nurses had difficulties understanding socio-cultural aspects of language, including jokes and sarcasm. This communication issue, including not being understood by others and not understanding others, creates much stress for internationally educated nurses and can lead to issues with patient safety (Tregunno et al., 2009). Moreover, studies conducted in

other provinces in Canada have shown that communication is a major barrier to the integration of internationally educated nurses (Beaton & Walsh, 2010; Hawkins, 2013; Higginbottom, 2011; Salma, Hegadoren & Ogilvie, 2012).

Going through the registration process, internationally educated nurses are faced with high costs, including those for tuition for refresher courses, the nursing examination, the language test, and the application process itself (Jeans et al., 2005). The burden of these costs is compounded by the fact that many internationally educated nurses are unemployed or underemployed. Furthermore, they often send a significant portion of their earnings as remittances to their country of origin to provide for the financial needs of family members (Sochan & Singh, 2007). Also, Walton-Roberts and Hennebry (2012) found that some nurses borrow money in order to migrate to Canada, which must be repaid. Even after their family members arrive in Canada, internationally educated nurses often prioritized their familial commitments and obligations (including their family's economic needs) over their nursing integration process (Ronquillo, 2012; Salma, Hegadoren & Ogilvie, 2012). Finally, internationally educated nurses had the challenge of dealing with the immigration process, which can be very confusing and heavily burdened with red tape (Jeans et al., 2005).

The findings of Jeans et al. (2005) parallel those of Baumann et al. (2006), who studied internationally educated Registered Nurses and Registered Practical Nurses. Baumann et al. (2006) completed semi-structured focus groups and individual interviews with 39 internationally educated nurses and 32 key informants in Ontario. This study took into consideration the region specific difference in barriers to practise in Canada by focusing on Ontario. Baumann and her colleagues found that immigration status posed a barrier for internationally educated nurses, especially for those migrating under the Live-in Caregiver Program, who may not have sufficient

time to prepare for the licensing examination. This finding is consistent with that of a study by Sochan and Singh (2007), who interviewed a convenience sample of twelve internationally educated nurses who were completing upgrading courses to become nurses in Ontario. The problems of those who migrated under the Live-in Caregiver Program resulted from their inability to take refresher nursing courses or apply to become registered to practise in Ontario during their two-year live-in caregiver contract (Sochan & Singh, 2007). Hawkins (2013) explained that an over-arching obstacle for nurses who migrate to British Columbia as live-in caregivers was the nature and restrictions of their legal status in Canada. Other barriers identified in the literature include insufficient practical information on the process of migration, lack of support systems post-migration, difficulty in obtaining documents from their country of origin, difficulty in passing the licensing examination, and systemic discrimination (Baumann et al., 2006; Hawkins, 2013; Higginbottom, 2012; Salma, Hegadoren & Ogilvie, 2012).

Research studies by Jeans et al. (2005), Sochan and Singh (2007), as well as Baumann et al. (2006) indicated that immigration status posed a barrier for internationally educated nurses in Canada. The findings of Baumann et al. (2006) and Sochan and Singh (2007) emphasize the plight of live-in caregivers in their attempts to integrate into the Ontario health care system. The preliminary results of a similar study on Philippine nurses in Ontario (conducted at the same time as this thesis) also alluded to the great difficulties faced by nurses who migrate through the Live-in Caregiver Program in becoming registered to practise (Walton-Roberts & Hennebry, 2012). The recent study by Hawkins (2013) found that nurses who migrate to British Columbia through the Live-in Caregiver Program face a more precarious nursing integration process (as compared to those who migrate through the Federal Skilled Worker Program and the skilled Temporary Foreign Worker Program). However, limited research has been done on the workforce

integration of internationally educated nurses migrating to Ontario through the Live-in Caregiver Program. Even though individuals have different labour market experiences based on their immigration stream (e.g., temporary immigrant versus permanent resident), to date, no study in Ontario has examined the process of workforce integration based on immigration class (i.e., Family class, Live-in Caregiver Program or Skilled Worker Program) or immigration status (permanent versus temporary) in Ontario and there is limited research across Canada.

Global Health Workforce and Ethics

The World Health Organization estimates that the global shortage of healthcare professionals is 4.3 million (World Health Organization, 2006). Ethical issues surrounding the migration of nurses have been the subject of growing discussion (Pittman, Folsom, Bass and Leonhardy, 2007; Plotnikova, 2012). Of major concern is the active recruitment of health care professionals from countries with a severe nursing shortage (International Council of Nurses, 2007; International Council of Nurses, 2008; World Health Organization, 2006; World Health Organization, 2010a). This recruitment creates further pressure on nursing human resource planning in these countries. Focusing on the risk to health outcomes in developing countries, Plotnikova's (2012) emphasizes the need to focus on the right to health of individuals in developing countries in guiding health human resource policies.

In the face of controversy concerning recruitment from countries that suffer a severe shortage of health care professionals, Kingma (2006), Runnels, Labonte and Packer (2011) as well as McIntosh, Torgerson and Klassen (2007) propose that countries set policies that not only consider the active recruitment pattern, but also the passive recruitment of health care professionals. Noting that Canada does not distinguish between active and passive recruitment,

McIntosh et al. (2007) view active recruitment as targeting health professionals in source countries and enticing them to migrate to destination countries, while passive recruitment is defined as individuals who take action to migrate to Canada.

Runnels et al. (2011) notes that the advent of information technology, especially Internet advertisement, blurs the lines between active and passive recruitment. In a study by Runnels, Labonte and Packer (2011) that included interviews of 26 recruiters in Canada, all but two participants noted that they did not “directly” (or actively) recruit internationally educated health professionals from outside Canada. One recruiter stated “we don’t go knocking on anybody’s door outside of North America” (p. 3) and another stated “I shudder at the word ‘recruit’ internationally.... other than offering information, we’re not actively soliciting them” (p. 3). Recruiters also discussed how they placed advertisement on their website and employment websites (Workopolis, Charity Village and Monster.ca); in this way, these recruiters thought they were not actively recruiting. Although no participant stated they recruited directly by advertising in foreign academic medical journals, the researchers found advertisements by Canadian health organizations in printed copies of the South African Medical Journal, indicating active recruitment. Although the cases of Internet advertising on Canadian websites and advertising in foreign journals are at the opposite ends of the spectrum of active versus passive recruitment, most times the fluid boundary between active and passive recruitment is a value judgment (McIntosh, Torgerson & Klassen, 2007).

From interviews with 21 recruiters, 18 hospital Chief Nurse Executives, as well as an Internet search of recruiters’ websites, Pittman, Folsom, Bass and Leonhardy (2007) counted a total of 267 international nurse recruitment firms operating in the United States in 2006; a marked increase from the 30 to 40 such firms in the late 1990s. Although the firms interviewed

stated they were not recruiting from developing countries that face a severe nursing shortage, the researchers found through an Internet search that at least 40 of the United States firms recruited from such countries (including 25 firms recruiting in Africa). In the same study, interviews with internationally educated nurses (especially those who work in nursing homes) revealed questionable ethical practices, including imposing excessive demands to work overtime, paying below the stated compensation rate of domestic workers (i.e., workers educated in Canada), threatening deportation if nurses do not comply with excessive demands, retaining immigration and travel documents, delaying payments and requiring excessive fees from those who breach their contract.

Indeed, a study by Runnel et al. (2011) indicated that the focus of recruiters was less on ethical recruitment than on meeting performance expectations and employer's needs. Recruiters stated they provided useful information to internationally educated health professionals related to licensing, regulation, and education. Most of the recruitment agencies interviewed had no policies or guidelines in place related to ethical recruitment. Even in the few cases where recruiters have an ethical recruitment policy, it was often weak in addressing the depletion of health human resources in hospitals and regions with shortages. For example, Runnel et al. (2007) discussed the Saskatoon Health Region's nurse recruitment trip to the Philippines. Their ethical statement restricts the recruitment of experienced nurses to a maximum of five per hospital department; what was not considered is that hospital departments who lose staff will need to replace these nurses with lesser or newly qualified nursing staff. In fact, Perrin, Hagopian, Sales and Huang's (2007) survey of hospital Chiefs of Nursing in the Philippines found that a major problem was the ability to retain experienced nurses who were often lured to migrate.

McIntosh et al. (2007) conducted thematic analysis of international documents on ethical recruitment and interviewed 16 key informants in Canada. In interviews with stakeholders in Canada on the ethical recruitment of health care professionals, guiding principles that stakeholders discussed included: global justice, personal justice, personal autonomy, transparency and accountability, fairness, mutuality of benefits or reciprocity, provider competency, equitable workplace practices, and workplace and cultural integration. The researchers argued that while health human resource planning takes into consideration the domestic context of the issue of workforce shortage, the broader ethical implications should also be considered, especially in terms of a global skill waste. In fact, the right of an individual nurse to migrate competes with the depletion of health human resources in countries which suffer severe shortages. Several international policy documents have commented on the competing perspectives between the depletion of health human resources in countries with a nursing shortage and the right of nurses to migrate (International Council of Nurses, 2007; World Health Organization, 2006, 2009, 2010b). The International Council of Nurses (2007) denounced the unethical recruitment of nurses to work in lower skilled occupations, which exacerbates the problems at the global level.

Nurse Migration from the Philippines

The Philippine government has had an explicit nursing export policy since the 1970s (Masselink & Lee, 2013). A high number of Filipino professionals working in other countries equates with high remittances, which boost the economy (Lorenzo, Galvez-Tan, Ikamina, & Javier, 2007). In the year 2011, \$23 billion was sent in remittances to the Philippines by expatriates (World Bank, 2012). It is no surprise that migrant Filipinas are viewed by the

Philippine government as national heroes for their economic contribution to the country through remittances (Rodriguez, 2002). Canada ranks third (after the United States and Saudi Arabia) as a source country of remittances to the Philippines, with \$1.921 billion in remittances sent from Canada to the Philippines in 2011 (World Bank, 2012).

In addition to financial gain from remittances, the push factors for emigration of Filipino nurses include low salary, poor working conditions, lack of employment opportunities, and outdated health care technologies (Dimaya, McEwen, Curry, & Bradley, 2012; Lin, 2013; Ronquillo, 2012), as well as cultural pressures to migrate and become “modern day heroes” (Ronquillo, Boschma, Wong, Quiney, 2011). The pull factors include higher salary, better working conditions, foreign visa provisions for family (Dimaya, McEwen, Curry, & Bradley, 2012; Lin, 2013; Ronquillo, 2012), as well as a desire for higher status (Ronquillo et al., 2011). Filipino nurses are highly sought in the global marketplace because they are often fluent in the English language, are educated in the North American system of nursing (Masselink & Lee, 2010; Ronquillo et al., 2011), and are often trained by United States educated instructors (Lin, 2013). On migration to North America, their ability to rapidly acculturate to the North American system of nursing is positively correlated with their job satisfaction (Berg, Rodriguez, Kading, and De Guzman, 2004). Filipino nurses in North America report moderate (Ea, Griffin, L’Eplattenier, & Fitzpatrick, 2008) to high job satisfaction (Berg, Rodriguez, Kading, & De Guzman, 2004), despite initial challenges with communication, culture, and adjustment to the North American system of health service delivery (Lin, 2013; Ronquillo, 2012).

While the Philippines remain a major exporter of skilled professionals, there is still much concern about the quality of its educational programs (Valenzuela and Caoili-Rodriguez, 2008). As of 2008, only 19 percent of all higher education academic programs in the Philippines

achieved accreditation, a voluntary process for educational institutions in the Philippines. While concerns over program quality remain, they have had little or no effect on the emigration of skilled professionals (especially nurses) from the Philippines. Masselink and Lee (2010) argue that the increasing number of schools of nursing in the Philippines has had detrimental effects on the quality of educational programs in the country. Private colleges have sprung up in the Philippines over the last decade to train nurses for the global workforce. In 1950, there were 16 nursing schools in the Philippines; by 1970, there were 40 nursing schools; by 2003, there were 230 nursing schools; and by 2005, there were 441 nursing colleges in the Philippines (Asis, 2007; Choo, 2003; Lorenzo et al., 2007). More than 80 percent of these nursing schools are privately owned and follow a business model (Kanchanachitra et al., 2011). Furthermore, doctors in the Philippines are increasingly re-training as nurses to secure more lucrative pay and emigrate out of the Philippines (Masselink & Lee, 2010). Hence, nursing schools in the Philippines have become “the gatekeepers of migration opportunities” (Masselink & Lee, 2010, p. 169).

Given the growing number of nursing schools, it is unsurprising that in 2007, the Philippines produced more than 60,000 nurses (Kanchanachitra et al., 2011). Yet the number of licenses issued to practice nursing in the Philippines continues to decrease dramatically, from 27,000 in 1995 to 5,800 in 2000 (Choo, 2003). While the number of nursing schools in the Philippines continues to increase, the corresponding decrease in nursing registration exam success rate in the Philippines is a concern (Brush & Sochalski, 2007). The poorer exam success rate is a symptom of the depreciating quality of nursing education in the Philippines (Brush & Sochalski, 2007; Masselink & Lee, 2010). To compensate for this poor success rate, 90 percent of nursing schools in the Philippines are affiliated with licensure exam review centres to leverage their graduates’ ability to enter the nursing workforce (Masselink & Lee, 2010).

Lorenzo et al. (2007) pointed to the deliberate oversupply of nurses in the Philippines. The stock of nurses in the Philippines is 332,206, the demand is 193,223, and the oversupply is 139,983. Of the 193,223 employed nurses, 29,467 (15.25%) are working locally or nationally while 163,756 (or 84.75%) are working internationally (Asis, 2007; Lorenzo et al., 2007). Of even more concern is the 42 percent of nurses from the Philippines who are not employed as nurses, either in the Philippines or internationally. In 2009, more than 400,000 licensed nurses in the Philippines were not employed in the nursing profession (Kanchanachitra et al., 2011). According to Lorenzo, Galvez-Tan, Ikamina, and Javier (2007) and Kanchanachitra et al. (2011), there are no data on why these nurses left the profession or specifically what they are doing outside the profession. The chairman of the board of conveners of the Asia-Pacific Research Network explained that the declining trend in the number of Philippine nurses registered to practice is due primarily to the emigration of trained nurses who work as nurses in other countries (where they register) or who submit to “deskill[ing] to emigrate to more affluent countries as caregivers or even domestic aides” (Choo, 2003, p. 1356). The high possibility of this recruitment pattern demonstrates a need to explore the literature on nurse migration as domestic workers.

DOMESTIC WORKERS AND LIVE-IN CAREGIVERS

Global Migration of Domestic Workers

Migrant domestic care workers are increasingly in demand as caregivers for older adults in several countries of the developed world, including the United States, Canada, the United Kingdom and Ireland (Spencer, Martin, Bourgeault, & O’Shea, 2010). Spencer et al. (2010) argue that this demand is largely due to the underfunding of older adult care, as well as the low wages and unfavorable working conditions in this sector. In Canada, funding for home care and

community care has remained constant while expenditures continue to rise (Bourgeault et al., 2010). The International Labour Organization (2010) states that the demand for live-in caregivers and domestic workers in several countries is driven by the aging population, the feminization of international migration, the diminishing state provision of care services, as well as the incorporation of women into the labour force without policies in place to reconcile the demand of family life (such as child care) and work. Summing up these reasons, Khoo, MacDonald, Voigt-Graf, and Hugo (2007) argue that the primary reason for the recruitment of temporary foreign migrant workers is that the required skill is difficult to obtain in the destination countries.

The Philippines is the top source country of migrant care workers in the four countries (United Kingdom, Canada, Ireland and United States) studied by Spencer, Martin, Bourgeault and O'Shea (2010). In 2006, according to the Philippine Overseas Employment Administration (2007), 91,412 domestic workers (98.3% of whom were females) emigrated from the Philippines while 13,525 professional nurses emigrated from the Philippines. This figure excludes the 6,706 who emigrated as cleaners and 14,412 who emigrated as caregivers and caretakers.

Migrant domestic workers are vulnerable to exploitation and abuse. For instance, anthropologist Nicole Constable (2007), in an ethnographic field work on domestic workers in Hong Kong, which included participant observation, interviews, and archival research, found that migrant domestic workers are often exploited by recruitment agencies that require them to pay illegal recruitment costs that may equal up to seven months' earnings. Contracts between recruiters and employers may also be exploitative. In Constable's (2007) study, some contracts of domestic workers included statements such as, "On your day off, you must be back home by 10:00 P.M. and you can never stay out overnight" (p. 84); "You must never use the phone

without permission from your employer” (p. 84); “You must never go out without permission unless there is an emergency” (p. 84); “You must not attend any religious rituals other than simple prayer before rest at night in the house of your employer” (p. 85); “You are not allowed to rest and lean on sofa of the parlor and your employer’s bed” (p. 94); “Do not put on makeup, even when you are going out to do the family shopping; Your hair must be short and tidy” (p. 94).

In a report outlining the situation of migrant domestic workers worldwide, the International Labour Organization (2010) argues that a contributing factor to the maltreatment and exploitation of domestic workers is the absence of policies or laws in receiving countries that protect these workers. Not only are migrant domestic workers frequently excluded from labour legislation in destination countries, they also face several practical barriers, some related to domestic workers’ ignorance of their rights and the lack of enforcement of existing legislation pertaining to their rights. Even when domestic workers are aware of their rights, they fear jeopardizing their job and immigration status; hence, it is not uncommon for migrant domestic workers to work awkward schedules to satisfy their employers who have some control over the domestic workers’ immigration status. In the Middle East, domestic workers can face especially challenging conditions. For instance, in Kuwait, domestic workers and housemaids work an average of 70 to 100 hours a week, and many live-in migrant domestic workers in Netherlands are expected to work at any time (International Labour Organization, 2010). Moreover, in many countries, migrant domestic workers often face discrimination in training and promotion (International Labour Organization, 2010; Spencer, Martin, Bourgeault, & O’Shea, 2010).

Domestic workers perform diverse sets of tasks, including cleaning and taking care of children, the elderly and the disabled. While some workers may have little or no experience,

others are practical nurses, registered nurses, physicians, occupational therapists, physical therapists, home support workers, and care managers (Spencer, Martin, Bourgeault & O'Shea, 2010). The tasks that skilled migrant domestic workers perform inside their employers' homes are often not clearly defined at the outset of the contract, but frequently demand flexibility with respect to working conditions, hours and forms of payment (International Labour Organization, 2010).

At times, domestic workers may perform the duties of a skilled nurse such as dispensing medication and tracheostomy care (Tung, 2000), however, they are paid much less than if they were hired as a nursing professional. Similarly, Stacey (2011), who interviewed untrained home care aides, found that some of them provided skilled care, such as changing Foley catheters, and became pseudo nurses by default. Tung (2000) found that while the cost of caring for an elderly person with a tracheostomy in the United States by a Filipino live-in caregiver is \$70 a day, the cost would have been \$756 a day if a Practical Nurse was hired to provide the same service. Constable (2007) found that some individuals who were hired and paid as domestic workers in China were also conducting ultrasound examinations in their employers' office.

The experience of immigrant nurses in the United Kingdom who work as unskilled care workers has been studied by Cuban (2010), who interviewed 23 immigrant health care professionals in England (20 of whom were internationally educated nurses) who were senior carers (providing elder care) and general carers. She also observed 16 of these women in their workplaces, homes, and educational institutions. The women interviewed included six Filipinas, four Romanians, nine Indians (mainly from Kerala), one Malawian, and one Chinese. Most of these women migrated through recruitment agencies that promised them a good income as carers while they qualified as nurses in the United Kingdom. The educational level of these women

leveraged their ability to go abroad, however, pre-migration, these nurses did not know the meaning of being a “carer” or the barriers to becoming a health care professional in England. On arrival, the women were faced with unexpected costs, university accreditation problems, lack of mentors, minimal access to programs, lack of education, and uneven assessment procedures and policies in the profession. This situation was complicated by visa and work regulations that led to “dead end” jobs as carers in nursing homes. Many of the women in Cuban’s study reported feeling depressed during the process of accreditation. Their poor emotional health was compounded by dubious employment agencies that charged enormous amounts of money and did not fulfil their promise of assisting these women to become professionals in England.

Similarly, Nakache (2010) found that temporary migrant workers in Canada frequently testified that they had been misinformed by labour brokers (including recruiters and employment agencies) to believe that a temporary migration visa was a first step in becoming a permanent resident. Agencies commonly charged high fees, supposedly for permanent migration, with no guarantee that temporary migrants would receive this status. This gap is critical, as Oxman-Martinez et al. (2005) noted that for many individuals who migrate as live-in caregivers to Canada, the main appeal of the Live-in Caregiver Program is eventual acceptance as permanent residents in Canada.

Another important reason for the migration of female domestic workers is to provide a better life for the children they leave behind (Tung, 2000). In interviews with 82 domestic workers in Los Angeles and Rome, Parrenas (1998) found that domestic workers are “emotionally assaulted” because they are unable to provide emotionally for the children they leave behind and because of their downward occupational mobility. The misery resulting from the downward occupational mobility of educated migrant domestic workers is further aggravated

by the authority practiced by their employers and employer's children, particularly in difficult or abusive situations.

Constable (2007) observed and was informed by participants in an ethnographic field study about the maltreatment of domestic workers (particularly Filipinas and Indonesians), including demands to work 18 hours a day, being shouted at, burned with an iron by an angry employer, made to sleep on the floor, given only leftovers to eat, forced to have their hair cut, beaten, locked in a room, starved, forced to do illegal work, and physically and sexually abused. She also found issues of racism in the recruitment of live-in caregivers; for instance, she stated that Chinese women do not like to hire Filipino women with darker skin because as one recruiter stated "they scare the children...if the children see them it will make them cry" (p. 75).

In extreme cases, deaths have been reported. Human Rights Watch (2008) noted that from January 2007 to August 2008, more than 95 migrant domestic workers died in Lebanon. Of the known cases, only 14 were due to health or disease conditions, while 40 were due to suicide, and 24 were caused by domestic workers falling from a building, usually in an attempt to escape from their employers. In 2011, an Indonesian domestic worker was beheaded in Saudi Arabia after she was convicted of murdering her employer (Telegraph, 2011, June 23).

Despite these many reported incidents of exploitation, abuse, and discrimination, a study conducted of low skilled care workers in four countries (Canada, United Kingdom, Ireland and United States) revealed that migrant personal care workers are largely responsible and hardworking individuals who have been identified by employers as contributing positively to their quality of life, although communication issues (with the English language) exist (Spencer et al., 2010). Given the risk of exploitation and maltreatment of care workers, however, these

researchers concluded that migrant care workers are not the solution to meet the care needs of older adults in developed countries (Spencer et al., 2010).

Statistics on Canada's Live-in Caregiver Program

The Live-in Caregiver Program is the migrant domestic worker program in Canada. In total, 52,493 individuals arrived in Canada as principal applicants through the Live-in Caregiver Program between 1993 and 2009 (Kelly, Park, de Leon, & Priest, 2011). More than 95 percent of these live-in caregivers were women. The Philippines remain the top source country of live-in caregivers in Canada, accounting for 80 percent (Kelly, 2006). Live-in caregivers are increasingly well educated (Kelly et al., 2011). The predominant destination province of live-in caregivers is Ontario, with over 49 percent (6,143) settling in this province in 2009 (CIC, 2010). Table 1 illustrates the destination province of live-in caregivers in 2009.

Shifting trends in the number of live-in caregivers in Canada (CIC, 2012) suggest that certain policy changes (such as mandating employers to pay all live-in caregivers' recruitment fees since 2009) have caused a reduction in the program. Between 2000 and 2007, the numbers of live-in caregivers entering Canada steadily increased, peaking at 12,955 in 2007; since 2009, the opposite trend is evident with 6,242 admitted in 2012 (CIC, 2013a).

Research on Canada's Live-in Caregiver Program

Research on live-in caregivers in Canada reveals that this population experiences marginalization, exploitation, social exclusion, and non-citizenship (Cohen, 2000; D'Addario, 2012; Pratt, 1997; Stasiulis & Bakan, 2005; Spitzer, 2009). Moreover, researchers argue that nurses who migrate to Canada through the Live-in Caregiver Program commonly experience

deskilling and barriers to entering the nursing workforce (Pratt, 1999; Philippine Women Centre, 2000; Zaman, 2006). The negative experiences of live-in caregivers in Canada is influenced largely by the policies of the Live-in Caregiver Program, including the two-year temporary immigrant status, the live-in requirement, the inability to live with one's children, and the restriction on taking courses (Philippine Women Centre, 2000; Stasiulis and Bakan, 2005).

Of concern to the Canadian Department of Justice is the human trafficking and exploitation by recruitment agencies that may occur in the recruitment of live-in caregivers. In a project commissioned by the Canadian Department of Justice, Oxman-Martinez, Lacroix, and Hanley (2005) interviewed several community agencies and found human trafficking to be very common in the Live-in Caregiver Program. Representatives from community agency groups described how many live-in caregivers endured “forced labour and slavery-type practices” (p. 7) as well as sexual exploitation by recruitment agencies on arrival in Canada. This type of abuse takes many forms. For instance, one Filipino nurse who migrated under the Live-in Caregiver Program was asked by her employer, “during your spare time, could you do something for me? Can you give me a blow job” (Philippine Women Centre, 2000, p. 21).

Stasiulis and Bakan (2005) also found evidence of financial exploitation in the Live-in Caregiver Program. These researchers interviewed 50 domestic workers in Canada (25 from the Philippines and 25 from the Caribbean), recruited mainly in Ontario through snowball sampling⁵. They found that while the minimum wage in Ontario was \$6.85 per hour, on average, live-in caregivers were being paid from \$4.53 per hour (for West Indian domestic workers) to \$4.73 per hour (for Filipino domestic workers). Moreover, some domestic workers from the Philippines

⁵ Snowball sampling is a non-probability sampling procedure where previous study participants help in recruiting new participants from among their social network.

were being paid as low as \$1.91 per hour, while West Indian domestic workers were paid as low as \$2.14 per hour. Deductions for room and board further limit the income of these workers.

These results are consistent with those of Zaman (2006), who interviewed 50 Filipina women recruited from the Philippine Women Centre in British Columbia (most of whom had migrated through the Live-in Caregiver Program). The live-in caregivers interviewed reported that their employers often do not comply with labour regulations or clauses in their employment contract regarding hours of work, wages, and vacations. Live-in caregivers often do not want to challenge their employer because they risk losing their job and not being able to get another job without employer references. They also fear that they will not be able to become a permanent resident in Canada if they are unable to find a job in Canada. These concerns are quite rational since some live-in caregivers have not been able to become permanent residents. Of the live-in caregivers that migrated to Canada in 2003, only 60 percent had become permanent residents by 2007 (Valiani, 2009).

This financial exploitation creates challenges for live-in caregivers who are struggling to settle in Canada and send remittances to their country of origin. The importance of being able to send remittances and become permanent residents in Canada (with their family) was evident in the findings of Stasiulis and Bakan (2005): 19 of the 25 domestic workers from the Philippines who were interviewed rated the statement “I want to be able to earn money to send back home” as important or very important when asked about the factors that influenced their decision to come to Canada; and 18 of the Filipinos rated the statement “I want to bring over my family or certain family members to Canada” as important or very important.

Being able to sponsor family members is an important issue for live-in caregivers who are the only migrants (apart from seasonal farm workers) unable to sponsor their family to come

with them to Canada. According to current policies, live-in caregivers are unable to sponsor their families until a minimum of 22 months after they have completed the live-in caregiver program and become permanent residents in Canada (CIC, 2013a). In a study, based on the experience of 11 live-in caregivers in Toronto who have reunited with their families, two counselors and two community workers at INTERCEDE (an advocacy organization), and an immigration officer, it was found that it typically takes seven to ten years after migrating from the Philippines for domestic workers to reunite with their families as permanent residents in Canada (Cohen, 2000). During this time, they need to send remittances home. The counselors and community workers reported that once a caregiver becomes a permanent resident, it costs about \$10,000 for her husband and two dependent children to migrate to Canada, which is an enormous financial burden which may impair her ability to seek professional status.

Live-in caregivers also struggle with social exclusion (McKay, 2002), isolation (D'addario, 2012), non-citizenship (Daenzer, 1997; Pratt, 1997), and problems with family reunification (Cohen, 2000; Pratt, 2009). McKay (2002) interviewed 42 Filipina live-in caregivers and found that 29 of them experienced social exclusion and stereotyping by other Filipinas who migrated as skilled workers. Social exclusion is compounded by the requirement to live and work in the client's home, which provides little opportunity for interaction within or outside the Filipino community.

Daenzer (1997) argued that domestic workers must relinquish several citizenship and social rights, such as the right to live in one's own home, the right to choose one's place of residence, and the right to live with one's children, because of the policies of the Live-in Caregiver Program. D'addario (2012) found that live-in caregivers in the outer suburbs of Toronto experience social isolation. To assuage the pain caused by social isolation, some live-in

caregivers create spaces of belonging by sharing weekend homes with other live-in caregivers (Palmer, 2010).

Live-in caregivers experience struggles with family reunification because of the minimum two-year separation from their children (Cohen, 2000; Pratt, 2009). Reuniting with family is often made more difficult and complex because live-in caregivers are sometimes advised by recruitment agencies to falsify information such as marital and parental status prior to coming to Canada (Cohen, 2000; Pratt, 1997). Once family members are reunited, they are often plagued by tension and conflict, including marital separation, and in at least one reported case in Toronto, domestic violence resulting in murder and suicide (Cohen, 2000). Mothers from the Philippines who left their children behind for years are often later judged as “bad mothers” when social problems arise among their reunited children (Pratt, 2009). Pratt’s (2009) findings are consistent with those of her previous study a decade earlier which found that live-in caregivers are often negatively stigmatized (including being stigmatized as a “husband stealer”) within the Filipino community (Pratt, 1999).

Similarly, Constable’s (2007) research on Filipina domestics in Hong Kong found that live-in caregivers are stigmatized in their destination countries, including by employers. One employer of Filipino domestic worker in China remarked that “Filipinas... are very stupid... What else? ... Why would they willingly leave children and husbands behind in the Philippines?” (p. xiii). Given that social networks are critical for hearing about job openings, the stigma faced both within the Filipino community and within the general population is a concern, as it has the potential to exclude live-in caregivers from valuable employment networks (Pratt, 1999). Their status as non-citizens and feelings of exclusion make some live-in caregivers

hesitate to apply for unemployment insurance when they are eligible, which further hinders their integration into Canadian society (Pratt, 1999).

The marginalization and social exclusion of live-in caregivers begins even before they migrate to Canada. Nanny recruiting agents in British Columbia expressed views indicating that they considered live-in caregivers from Europe as professionals while those from the Philippines were viewed more as servants (Pratt, 1997). For instance, Filipina applicants were instructed by recruiters to include pictures of them cleaning, which European nannies were never instructed to include. Pratt (1997) argues that such practices lead to the de-professionalization of the live-in caregiver, even before arriving in Canada. Williams (2012) found similar racialized hierarchies in the employment of domestic workers in Europe.

Research on Nurse Migration through the Live-in Caregiver Program

Issues of de-professionalization, deskilling, and barriers to entering the workforce are reflected in the work of McKay (2002), Pratt (1999), Philippine Women Centre (2000), and Zaman (2006), all of whom conducted research in Vancouver, British Columbia, by recruiting participants through the Philippine Women Centre of British Columbia and its subgroup, the Filipino Nurses Support Group. McKay (2002) interviewed 72 Filipina women, 42 of whom migrated through the Live-in Caregiver Program. Of those interviewed, 32 had work experience outside of the Philippines, including two who had experience as nurses outside the Philippines. To increase their chances of being able to migrate to Canada as live-in caregivers, women with professional training (nurses, teachers, or educators) applied to the program after gaining labour force experience in Hong Kong, Singapore, or Saudi Arabia. Live-in caregivers who are nurses,

midwives or educators think that they will be able to get jobs that suit their qualifications in Canada after they complete the Live-in Caregiver Program, but experience deskilling instead.

Pratt's (1999) research found an over-representation of skilled professionals in domestic work (as live-in caregivers) in British Columbia. In her article, "From Registered Nurse to Registered Nanny", she documented the plight of live-in caregivers (some of whom were nurses) in their struggle to become permanent residents in Canada. She interviewed 14 live-in caregivers, 10 live-in caregiver agents, and 52 families who had advertised for nannies. Several of the live-in caregivers referred to the barriers that impede their ability to become professionals (including professional nurses) in Canada. As one live-in caregiver stated:

There are plenty of restrictions. Just because you are a contract worker, you don't have any other choice to improve or develop yourself. It takes two years before you can have an open visa here in Canada. By that time you shall have been deskilled and it becomes extremely difficult to get other jobs beside housework. So your past training is almost nothing. If you are a nurse and if you haven't worked as a nurse for two years, you can hardly go back to the profession anymore. Two years is a long time. (Pratt, 1999, p. 223)

Another live-in caregiver commented that "after you have not worked for two years in the trade or profession that you have trained for, you begin to doubt if you still have the ability to do your previous work" (Pratt, 1999, p. 223). Hence, live-in caregivers struggle to retain their occupational identity as an educated professional.

Habiba Zaman (2001; 2006) also investigated the deskilling of Filipina women (including nurses) in Canada and interviewed 50 Filipina women from the Philippine Women Centre, some of whom were nurses. She found that even though many nurses who migrate as live-in caregivers take care of the chronically ill elderly, and apply their professional experience and educational

training, this educational training and experience is not recognized in the Canadian job market. Yet once employers realize the live-in caregiver they hired for elder care is an educated nurse, they often expect these nurses to perform professional level tasks in the home (Zaman, 2006). These women's skills were professionally exploited to the advantage of employers, but without any financial gains for the women. Nurses migrating as live-in caregivers to Canada continue to experience low wages and long hours of work and after a while working as a live-in caregiver, many lose their self-esteem and confidence in becoming Registered Nurses. According to Zaman (2006), "the LCP perpetuates commodification of labour that ties a domestic worker to a private home, free from the provincial government's labour regulations" (p. 81). All this contributes to the deskilling of nurses who migrate to Canada as live-in caregivers.

Eight years after she first interviewed women in the Live-in Caregiver Program, Geraldine Pratt (2005) re-interviewed these 15 women, most of whom were formerly professionals in the Philippines, but continue to do domestic work as low skilled home care health workers and housekeepers. Only one of these was able to return to her previous (nursing) profession in the interim. The study highlights the process of deskilling of professionals who migrate through the Live-in Caregiver Program. The one former live-in caregiver who was able to enter the professional (nursing) workforce experienced great challenges, including the completion of one-year refresher course, while working in numerous unskilled jobs.

Before migrating to Canada, professionals who migrated as live-in caregivers assumed that they would receive credit for their experience and qualifications after the Live-in Caregiver Program (Zaman, 2006), including the informal learning about the culture of care in Canada, the building of relationships, and improvement to their English communication (Brigham & Bernardino, 2003). Some live-in caregivers try to return to school for re-skilling in Canada, but

find the financial costs while continuing to send remittances to the Philippines too onerous; those who succeeded in completing the process for accreditation received support from family members and the Filipino Nurses Support Group (of British Columbia) in completing the process of accreditation (Zaman, 2006).

Stasiulis and Bakan (2005) documented the political lobbying of the Vancouver-based Filipino Nurses Support Group (a subgroup of the Philippine Women Centre of British Columbia) to advance the rights of Filipino nurses in Canada (specifically those migrating through the Live-in Caregiver Program). This group sees “the inability of Filipino nurses doing domestic work to practice their profession ... as racist oppression on the part of public and private gatekeepers, all of whom disclaim responsibility for the injustices experienced by these non-citizens” (p. 162). The Filipino Nurses Support Group and the Philippine Women Centre of British Columbia have lobbied Citizenship and Immigration Canada to eliminate the Live-in Caregiver Program and to permit migrant nurses to become permanent residents in Canada. In addition, they have sought to influence nursing policies in British Columbia by lobbying the Registered Nurses Association of British Columbia (RNABC)⁶ and the British Columbia Nurses Union. In addition, Pratt (1999) documents how live-in caregivers develop another identity by interacting with staff and volunteers at the Philippine Women Centre in British Columbia, where they “learn to see themselves as exploited Third World women and to understand their situations within a socialist feminist theory of imperialism” (p. 232).

Of the 300 members (as of 2001) of the Filipino Nurses Support Group, 78 percent migrated through the Live-in Caregiver Program (Filipino Nurses Support Group, 2001). This support group claims that the over-representation of Filipino nurses in the Live-in Caregiver

⁶ RNABC as of 2005 is known as the College of Nurses of Registered Nurses of British Columbia (CRNBC).

Program (in 2001) was because after 1993, zero occupational points were allocated to nurses under the Canadian Immigration Act. A survey of nurse members and contacts, to which 101 people responded, revealed that 89 nurses had opened files with the Registered Nurses Association of British Columbia, 82 nurses had submitted the verification papers, 46 had completed English requirement, 6 were working under interim permit, 40 had passed the registered nurse exam, and 39 were working as nurses.

In 2000, the Philippine Women Centre released a report on a participatory action research project that explored the stalled professional development of Filipina nurses in British Columbia. The sample consisted of 26 nurses who earned their Bachelor of Science in Nursing in the Philippines and migrated to British Columbia under the Live-in Caregiver Program. These nurses were motivated to migrate to Canada because of the atmosphere in the Philippines that supports migration. Like Cuban's (2010) research on "carers" in the United Kingdom, some nurses were unaware of the meaning of live-in caregiver; they thought it was a form of private health care provider, similar to nursing, rather than domestic or nanny work.

Once live-in caregivers are in Canada, aspects of the Live-in Caregiver Program, particularly the mandatory two-year live-in caregiver requirement, create systemic barriers to becoming licensed to practise as a nurse in British Columbia (Philippine Women Centre, 2000), primarily because it often takes more than two years to become a permanent resident in British Columbia and be able to practise. Since many caregivers have worked in other countries as caregivers before coming to Canada, meeting the professional requirement of recent, safe nursing practice becomes almost impossible. Moreover, the Philippine Women Centre (2005) found structural barriers in achieving accreditation including high cost, lack of information to prepare for examination, discriminatory and inaccessible practices to waiving and appealing a test, as

well as “systemic racism”. Hence, this study found that on migration to Canada, Filipina live-in caregivers often become deskilled.

In a survey of 421 Filipinos in Toronto, Kelly, Astorga-Garcia, Esguerra, and the Community Alliance for Social Justice (2009) identified 133 individuals who had migrated to Canada as live-in caregivers. Unlike the situation in British Columbia, only 30 of them had healthcare-related qualifications: nine were qualified as nurses, eight as midwives, and seven as physical therapists. With the relatively small number of live-in caregivers indicating that they had received training in nursing, Kelly et al. (2009) stated that “the common stereotype of the nurse downgraded into a caregiver does not hold true among the survey respondents” (p. 22). While this study may not be representative, data collected from the Citizenship and Immigration Canada supports the idea that the number of nurses who migrate through the Live-in Caregiver Program is low (see Table 2). This is a somewhat suspect conclusion given that live-in caregivers are often told by recruitment agents to falsify information for immigration applications (Cohen, 2000; Pratt, 1997), and multiple studies find much higher proportions of trained health workers among migrant caregivers in Canada (Bourgeault et al., 2010; Philippine Women Centre, 2001; Pratt, 1999; Zaman, 2006). In Bourgeault’s (2010) survey of 75 migrant care workers across Canada providing low skilled elder care, including live-in caregivers and personal support workers, 44.12 percent were nurses prior to migrating to Canada. What is established and (consistently) supported by all researchers is that nurses do migrate through the Live-in Caregiver Program, and the healthcare professionals (including nurses) who migrate through the Live-in Caregiver Program are mainly from the Philippines. The data shown in Tables 2, 3, and 4 of this dissertation emphasize this point.

Kelly et al.'s (2009) research indicates that live-in caregivers tend to have a high level of education and professional experience. Of the live-in caregivers Kelly et al. (2009) surveyed, 79 percent had a college degree at the bachelors level or higher, yet two-thirds of them experienced downward mobility after completing the Live-in Caregiver Program. Kelly et al. (2009) attributed this downward mobility partly to the lengthy separation from professional work, especially among those with a multi-country migration pattern. This multi-country mobility was supported by Constable (2007), who found that many individuals she interviewed in the early 1990s in Hong Kong had migrated to Canada to work as live-in caregivers by the year 2005. This multi-country migration as live-in caregivers or domestic workers increases the amount of time of separation from professional (nursing) work, further impeding registration.

IMMIGRATION POLICY AND CURRENT INITIATIVES

Policy on Temporary Foreign Worker Program (including the Live-in Caregiver Program)

The downward occupational mobility of live-in caregivers is driven by the current policies and administration of the Temporary Foreign Worker Program (including the Live-in Caregiver Program). Canadian lawyers and researchers, Nakache and Kinoshita (2010) argue that there is too much complexity in the administration of the Temporary Foreign Worker Program (including the Live-in Caregiver Program). While the Canadian federal government is in charge of most aspects of immigration, provincial governments are largely in charge of civil rights regarding employment, health care, housing and education. Each level of government is restricted in its ability to solve the programs' flaws. Some of the challenges identified by Nakache and Kinoshita (2010) include communication gaps among the policy makers, unregulated and exploitative recruiting practices, and regulatory restrictions on the ability of

workers to change employer. Nakache and Kinoshita's (2010) conclude "that Canada's rules on the legal status of migrants admitted for employment have been largely structured according to one policy model for lower skilled workers, to discourage their integration, and two simultaneous policy models for skilled workers, to both discourage and assist their eventual integration" (p. 39).

Migration researcher Hennebry (2010) notes that the aim of Temporary Foreign Worker Program (including the Live-in Caregiver Program) is unclear and confused over whether it intends to address short-term labour shortages or provide a pathway to permanent residence for individuals whose skills will benefit Canada. There is more clarity with respect to the short-term and long-term goals for seasonal agricultural workers, who are required to leave Canada at the end of their contract. Individuals admitted to Canada through the Live-in Caregiver Program are temporary workers on a rocky path to permanent resident status, and it is Canadian citizenship that the applicants desire (Pratt, 2009; Zaman, 2006). Similar conclusions were reached by Khoo, Hugo, and McDonald (2008), whose study of Australian temporary migrant workers found that those coming from Asia migrated in the hope of becoming permanent residents and bringing their families to Australia where they believed they could achieve higher economic status.

In 2010, the Honorable Minister of Citizenship and Immigration, Jason Kenney⁷, attempted to clarify the role of the government in temporary migrant worker programs. When asked about the long-term consequences of the Temporary Foreign Worker Programs, particularly the government of Canada's intent to encourage live-in caregivers and individuals in the Canadian experience class to stay, his reply did not directly address the question:

⁷ Minister Kenney was the Minister of Citizenship, Immigration, and Multiculturalism at the time of data collection for this study in 2012. As of July 2013, Minister Chris Alexander is the Minister for Citizenship and Immigration.

Since 1992, the Live-in Caregiver Program (LCP) has been a unique stream of the Temporary Foreign Worker Program (TFWP) that facilitates qualified, low skilled foreign workers entering Canada. After working as live-in caregiver for two years, LCP participants may apply from within Canada to become permanent residents. Currently, over 90% of foreign nationals who enter Canada as a live-in caregiver with a work permit apply for permanent residence (PR) through the stream (Kenney, 2010, p. 11).

When subsequently asked about the eligibility of temporary foreign workers to access settlement services earlier in their stay in Canada, the Minister emphasized that “CIC has a duty to maintain quality settlement services for permanent residents, to assist in their integration into Canadian society” (p. 11). He further explained that temporary migrant workers need to have the skills required to perform the job that they came to perform in Canada, then shifted the duty to ensure the settlement⁸ of temporary workers to their employers, stating: “For all temporary foreign workers, CIC expects employers to take an active role in ensuring workers find their place in the community, as employers benefit directly from their presence” (p. 11). The emphasis of Citizenship and Immigration Canada is on workers and the employers who directly benefit from their labour (including live-in caregivers), and downplays the role of the Canadian government, an indirect beneficiary of the program.

Lowe (2010) notes a shift in focus in immigration policy in Canada toward the decentralization of the two-step migration process, and more emphasis on employers and

⁸ Differences exist between the terms settlement and integration. Settlement refers to short-term focused activities and processes of establishment in a new society (Valtonen, 2008). Integration is a more long-term goal-oriented dimension wherein migrants seek full participation in the cultural, political, economic and social life of their new society, while ensuring compatibility and retention of their cultural identity. Integration is a process as well as an outcome: “that stage at which the individual has actually attained equitable, satisfying and meaningful status, roles and relations to the formal and informal institutions in the society of settlement” (p. 7).

universities (in the case of the Canadian Experience Class), without the necessary expertise and resources these actors (i.e., employers) require. Nakache (2010) supports this observation, stating that employers often do not have the knowledge, time and resources to take on the role of assisting temporary migrant workers in their integration and settlement in Canada, and there are no incentives or enforcement for them to do so. Reitz (2010) further emphasizes that the increasing power of employers should be granted with great caution as it may increase the possibility of exploitation of temporary migrant workers.

Current Initiatives on Immigrant Integration

Consistent with Minister Kenney's explanation on the role of government in the integration of permanent immigrants to Canada, several projects have been implemented to enhance the integration of permanent immigrants to Canada. The Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualification represents a joint commitment by federal, provincial and territorial governments to improve the recognition and assessment of foreign credentials in regulated occupations (Human Resource and Skill Development Canada, 2009). This framework is based on the principles of fairness, transparency, timeliness and consistency. Nursing is one of the major target occupations in this framework (Human Resource and Skill Development Canada, 2009).

To address the pre-migration issue of immigrants lacking knowledge of the Canadian labour market, in 2010, Citizenship and Immigration Canada initiated the Canadian Immigration Integration Project in India, China, Philippines and United Kingdom, scheduled to run until 2014 (CIC, 2010). This project includes the delivery of in-person pre-departure orientation services to potential immigrants and includes online support from project partners in Canada (Canadian

Immigrant Integration Project, 2013). Only applicants to the Federal Skilled Worker Program and the Provincial Nominee Program are eligible for this project; temporary foreign workers (including live-in caregivers) are ineligible.

In collaboration with other government sectors in Ontario, the Ministry of Citizenship and Immigration and HealthForce Ontario (an agency created in 2006 to ensure Ontarians have the right number and mix of qualified healthcare providers) created the Fair Access to Regulated Professions Act in 2007 to ensure that registration practices in Ontario are fair, transparent, objective and impartial (Office of the Fairness Commissioner, 2010a). The Office of the Fairness Commissioner was created under this Act. Every year, regulated professions in Ontario (including nursing) are required to submit an annual report on their registration practice to the Fairness Commissioner, who in turn submits an annual report to the Minister of Citizenship and Immigration to ensure the implementation of the Fair Access to Regulated Professions Act. However, the Act does not monitor the discrepancy between how immigrants fare compared to those who migrate to Canada as live-in caregivers, refugees, and permanent economic migrants, nor does it offer any special consideration or services for temporary foreign workers (including live-in caregivers).

HealthForce Ontario created the Access Centre for Internationally Educated Health Professionals in response to the research evidence on barriers to integration of internationally educated health professionals. The Access Centre provides counseling service and resources to internationally educated health professionals to ease their integration into the Ontario healthcare system. Internationally educated healthcare professionals (including nurses) have access to a counselor through this office both before migration to Canada and after migration to Canada. Healthforce Ontario and the College of Nurses of Ontario (2013a) also have websites for

internationally educated nurses hoping to register to become nurses in Ontario. The College of Nurses of Ontario's website includes a welcome page, an introduction to the nursing profession in Ontario, a brief review of what Registered Nurses and Registered Practical Nurses can expect in Ontario, an overview of the registration classes, and a description of the seven requirements to become a nurse in Ontario.

In response to the body of research on barriers to workforce integration of internationally educated nurses (Blythe et al., 2009; Jeans et al., 2005; Sochan & Singh, 2007), several other programs have been implemented to ease the integration of internationally educated nurses in Ontario. Creating Access to Regulated Employment (CARE) for nurses was created in the fall of 2001 as a bridging program to improve access to the nursing profession for internationally educated nurses who reside in Ontario (CARE, 2013). This program was able to double the success rate of internationally educated nurses in Ontario writing the registration exam from 33 percent to 66 percent. With campuses in Hamilton, Windsor, London, Kingston, and Brampton, the program has helped over 1,000 nurses to begin practising their profession in Ontario. Live-in caregivers who have applied for permanent resident status (i.e., after completing their two-year requirement) and have been assessed by the College of Nurses of Ontario as having satisfactory English Language skills may use the services of the CARE Centre.

A major change to the practice requirements for Registered Nurses and Registered Practical Nurses in Ontario was implemented in 2005. The previous requirement of a three-year diploma was replaced by a four-year Bachelor's degree in Nursing to become a Registered Nurse in Ontario, and the certificate program was replaced by a two-year diploma in nursing to become a Registered Practical Nurse. At the same time, a program was created at York University to enable diploma qualified internationally educated nurses to receive their Bachelor of Science in

Nursing degree after completion of a two-year program (York University, 2013). The creation of this and other bridging and upgrading programs has assisted in increasing the success rate of immigrants taking the Canadian Registered Nursing Exam; the first time exam success rate of internationally educated nurses increased from 49 percent in 2004 to 70 percent in 2009 (Canadian Registered Nurse Exam, 2007; Canadian Registered Nurse Exam, 2010).

Furthermore, in 2009, the College of Nurses of Ontario reorganized and refined its tools to make it easier for internationally educated nurses to provide full and complete information and to assist the Baccalaureate Equivalence Working Group of the College of Nurses of Ontario to effectively assess the education and experience of internationally educated nurses in Ontario (College of Nurses of Ontario, 2010). These efforts resulted in an extra 105 Registered Nurses being able to practice in Canada that year. The College of Nurses of Ontario also harmonized their language requirement with other jurisdictions across Canada (Office of the Fairness Commissioner, 2010b), and later increased its English language score requirement, to be in line with other provinces (College of Nurses of Ontario, 2013a).

Coordination of nursing regulatory bodies across Canadian provinces has also improved. In 2011, the Canadian Council of Registered Nurse Regulators was formed to “promote excellence in professional regulation” (Canadian Council of Registered Nurse Regulators, 2013). Through this group’s work, the NCLEX-RN exam will be adopted for registered nurses’ entry to practice in Canada beginning in 2015. Prior to this, in 2009, nursing regulatory bodies in Canada created the *National Competency in the Context of Entry-Level Registered Nurse Practice* to ensure a national standard and ease mobility of health professionals across Canadian jurisdictions (College of Nurses of Ontario, 2009b). And to more adequately assess the knowledge and skills of internationally educated nurses prior to registration in Ontario, the College of Nurses of

Ontario employed the help of the Centre for the Education of Health Professionals Educated Abroad (CEHPEA) to create an objective structured exam in 2013 (CEHPEA, 2013).

These multiple initiatives have attempted to address many of the issues raised by researchers and advocates on the barriers to workforce integration of internationally educated nurses, and to improve labour market outcomes for skilled professionals migrating as permanent residents, while ensuring the competence of internationally educated nurses. With a focus on public protection, the College of Nurses of Ontario has attempted to strengthen its nursing assessment process by emphasizing the competence of internationally educated nurses (in both language ability and clinical skills). However, relatively little has been done for temporary migrant workers (especially live-in caregivers) on a policy level.

SUMMARY OF LITERATURE REVIEW

The Live-in Caregiver Program allows individuals to migrate to Canada to provide care to the elderly, children, and the disabled, while living in the client's home. Around half of live-in caregivers settle in Ontario (CIC, 2010). Evidence indicates that some nurses migrate to Canada through the Live-in Caregiver Program (Bourgeault et al., 2010; Kelly et al., 2009; Pratt, 1997; Philippine Women Centre, 2000; Walton-Roberts & Hennebry, 2012), the majority of them from the Philippines. While the total number of nurses coming to Canada via this pathway is unknown, this migration pattern warrants further investigation as part of the picture of internationally educated nurses in Canada. Evidence also suggests that nurses who enter Canada as live-in caregivers are exemplary cases of downward mobility of skilled immigrant workers.

There are two strands of interest regarding this migration trend. One strand represents the deskilling of internationally educated nurses in the midst of a nursing work-force shortage in

Canada (Tomblin-Murphy et al., 2009) and globally (World Health Organization, 2006; 2010a). Internationally educated nurses face significant barriers to workforce integration in Canada (Blythe, Baumann, Rheume & McIntosh, 2009; Jeans et. al., 2005), including their immigration status (Blythe, Baumann, Rheume & McIntosh, 2009; Hawkins, 2013; Jeans et. al., 2005; Sochan & Singh, 2007). Specifically, researchers have found that a significant number of internationally educated nurses who migrate to Vancouver, British Columbia, through the Live-in Caregiver Program become deskilled and face difficulties entering the nursing workforce (McKay, 2002; Philippine Women Centre, 2000; Pratt, 1999; Zaman, 2006). It is important to note that these groups of researchers have all recruited participants from the same advocacy organization in Vancouver, British Columbia (which has fewer live-in caregivers than Ontario). Also, while McKay (2002), Pratt (1999) and Zaman (2006) included nurses in their study, it is unclear exactly how many nurses were included. The only study that focused exclusively on nurses who migrate through the Live-in Caregiver Program was conducted by the Philippine Women Centre (2000), an advocacy group for Filipina live-in caregivers in British Columbia. While this study identified systemic barriers for live-in caregivers in British Columbia and provided recommendations to policy makers, the researchers took an explicit advocacy stance and did not explore the perspective of policy makers on this issue.

The second strand in the downward occupational mobility relates to the increasing reliance on temporary migrant workers in Canada and the issues of exploitation, marginalization, social exclusion, and human rights. Some authors have argued that live-in caregivers surrender citizenship and social rights upon migration to Canada, including the right to choose their place of residence and the right to live with one's children and family (Cohen, 2000; Pratt, 2009; Spitzer, 2009; Stasiulis & Bakan, 2005). Moreover, several researchers have documented cases

of abuse and exploitation of live-in caregivers. However, there remains a paucity of research on the perspective of policy stakeholders (including immigration policy makers and recruiters) with respect to these issues.

While the experiences of both internationally educated nurses and live-in caregivers in Canada have been well documented in the literature, there is little research on internationally educated nurses that migrate to Ontario as live-in caregivers and the reasons for the continuing migration of internationally educated nurse's through the Live-in Caregiver Program despite the challenges with workforce integration. Lastly, no research has explored the perspective of diverse stakeholders (immigration policy makers, nursing policy makers and professional bodies, recruiters, live-in caregiver advocacy groups, and employers) on the migration and integration of nurses to Canada through the Live-in Caregiver Program.

RESEARCH PROBLEM

Some nurses migrate to Canada through the Live-in Caregiver Program. The majority of these nurses are from the Philippines and Ontario is the predominant destination province. Little is known about the decision making processes, expectations, and experiences of Philippine educated nurses who migrate to Ontario through the Live-in Caregiver Program, or of stakeholders' views on nurses who are admitted to Canada through the program.

RESEARCH PURPOSE AND QUESTION

The purpose of this study is to examine the experiences of Philippine educated nurses who migrate to Ontario through the Live-in Caregiver Program as well as the views of

stakeholders on the nursing workforce integration of these nurses. The major research questions are:

1. Why do Philippine educated nurses migrate to Ontario through the Live-in Caregiver Program?
2. What are the expectations of Philippine educated nurses who migrate to Ontario through the Live-in Caregiver Program?
3. What are the experiences of nurses who migrate to Ontario through the Live-in Caregiver Program?
4. What are the views of stakeholders on the migration and integration of nurses who migrate through the Live-in Caregiver Program?

CHAPTER 3: THEORETICAL FRAMEWORK

INTRODUCTION

The concept of global care chains is the most commonly used concept to study domestic worker migration (Parrenas, 2001) and has been well used to study nurse migration (Yeates, 2005a). “Global Care Chains” is a transnational feminist concept coined by sociologist Arlie Hochschild to illustrate the interpersonal links across the globe that are based on the paid and unpaid work of caring (Hochschild, 2000). Hochschild’s (1983) treatise on emotional labour, as expressed in *The Managed Heart*, provides the foundational conceptual work that led to the development of the concept of global care chains. Work by subsequent global care chain theorists, especially Parrenas (2001), incorporates issues of class mobility, citizenship and the rights of live-in caregivers. Carens’ (2008) perspective on justice provides complementary ideas useful for exploring the international migration of nurses to Canada to work as live-in caregivers.

THEORETICAL BACKGROUND ON THE GLOBAL CARE CHAIN: EMOTIONAL

LABOUR

On studying the work of airline attendants and tax collectors, feminist labour sociologist Hochschild (1983) developed the term “emotional labour” to describe work that “requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others – in this case, the sense of being cared for in a convivial and safe place” (p. 7). In her book, *The Managed Heart*, Hochschild (1983) explains how feeling rules (and its associated social norms) guide emotional labour as they establish a sense of obligation that regulates emotional exchanges. She uses the analogy of how a bride who is preparing for a wedding ritual assumes the normal rights and obligations of the (generic) bride (p. 61), which in

turn influence her outward display of joy and radiance. In a similar way, institutional rights and obligations affect the emotional labour of individual workers.

According to Hochschild (1983), when institutions are involved, various forms of emotional management show up in institutional rules, customs, and objects. “This kind of labor calls for a coordination of mind and feeling, and it sometimes draws on a source of self that we honor as deep and integral to our individuality” (Hochschild, 1983, p. 7). Emotional labour is often a component of service industry work - including the airline and healthcare sectors. The commodity that is sold is the outward display of the emotional labour such as smiles and eye contact. The “role establishes a baseline for what feelings seem appropriate to a certain series of events” (Hochschild, p. 74). Hence, the mandate over feeling rules which guide emotional labour is established by an authority that sets out specific roles for individuals. There are inherent inequalities in these rules of feeling or emotional labour. For instance, the flight attendant is obligated to smile with warmth, but the passenger has the choice of whether or not to smile. As Hochschild puts it; “because the distribution of power and authority is unequal in some of the relations of private life, the managing acts can also be unequal” (pp. 18-19).

Building on Goffman’s work, Hochschild contrasts deep acting and surface acting. In his book, *The Presentation of Self in Everyday Life*, Goffman (1959) outlines a theory of how individuals present themselves to others based on their social roles and thereby guide and control the impression others form of them, a situation Goffman describes as a theatrical performance of social life. Hochschild defines this form of presentation of self as surface acting, an act of controlling one’s body language in response to a social activity or role.

Hochschild (1983), however, goes beyond this mere control of emotional expression, noting that individuals can also control their feelings to conform to their social roles. She defines

this as deep acting. For instance, she presents the case of students training to be clinicians in a camp for disturbed children. These students are taught not only to see the children as victims of deprived backgrounds, but also how to feel towards them, to be warm and loving to them, even when the children are screaming and kicking. This deep regulation of feelings is emotional work imposed by institutions and passed down the hierarchy. It results in an outward change in appearance. By passing such feeling rules down the social class hierarchy, the higher social class suits its own dispositions; consequently, the lower one's social status, the less the consideration given to one's feelings.

Inequalities in the emotional labour performed by men and women are evident, with women more likely to perform emotional work that suppresses their power (Hochschild, 1983). For instance, work that enhances the status and well-being of others (such as caring work) is normally performed by women and is much more likely to go unnoticed. Moreover, people in low status categories, such as women and people of colour, lack a status shield (a shield that can protect against feeling rules). Performing a high amount of emotional labour, as required for deep acting, can lead to deskilling. Commenting on the case of emotional management by airline agents, Hochschild explains this:

The lessons in deep acting ... are themselves a new development in deskilling. The "mind" of the emotion worker, the source of the ideas about what mental moves are needed to settle down an "irate," has moved upstairs in the hierarchy so that the worker is restricted to implementing standard procedures. In the course of offering skills, trainers unwittingly contribute to a system of deskilling. The skills they offer do not subtract from the worker's autonomous control over when and how to apply them; as the point is made in training. (p. 120)

In this sense, information, instructions, standards, and procedures are passed down through the chain of hierarchy to workers with minimal autonomous control.

GLOBAL CARE CHAINS

In her 2000 work, “The Nanny Chain”, Hochschild (2000) extended the idea of emotional labour to the work of domestic workers in the home, relating the idea of emotional labour to the concept of global care chains. These ‘chains’ are personal links among people across the globe based on the paid and unpaid work of caring. An example of this chain may involve someone (such as a live-in caregiver or domestic worker) from a developing country caring for a child of a wealthy family in a developed country. The domestic worker, consequently, hires a poorer woman in her native country (such as the Philippines) to care for the child she leaves behind. The domestic worker in the developing country (such as the Philippines) may have to rely on her older daughter to care for her own child. Thus, there is displacement of feeling and emotion across the globe, where a nanny’s love for her own child is displaced to another child for whom she is paid to care. What exists here is a series of chains that transfers the caring work from the rich to the poor, creating a “care drain”, as well as a form of “emotional imperialism” (Hochschild, 2004, p. 27). In using the term emotional imperialism, Hochschild argues that while gold and physical resources were extracted by the North from the South in the nineteenth century, today the new gold is love and care, a rich commodity that is extracted from the South for use in the North.

The case of live-in caregiver migration from the Philippines to Canada can be understood using the concept of global care chains, as individuals (mostly women) leave their families behind to care for children, the elderly, or the disabled in Canada. This form of emotional

imperialism is even more striking when one considers the case of (highly skilled) nurses from the Philippines who migrate to Canada to work as (low skilled) live-in caregivers. As Hochschild (2004) argues, while individuals can work as teachers, nurses or administrators for \$176 per month in the Philippines, they can migrate to North America and perform less skilled (but not less difficult) work as domestic workers, nannies or live-in caregivers, earning around \$1,400 a month.

Hochschild (2000) contends that this distribution of care becomes inequitable as the displacement of love from one child to another is often directed upward in wealth and power (that is, from the poor to the rich). This unequal global distribution of care leads to “surplus value”, a political economy term borrowed from Marx, in which surplus labour (in this case love) is extracted, over and above the reproduction of labour, from the poor for the benefit of the rich. Since what is given up is love, the emotional toll this places on domestic workers is obscured, yet enormous.

Hochschild (2000) attributes this toll to global capitalism, which has created an increasing demand for women in the labour market. In other words, she argues that the ultimate beneficiaries in the global care chains are multi-national companies, their owners and shareholders, who hire the social and emotional labour of women (and men) but avoid paying for the domestic labour deficit in workers’ families. To compensate for this, middle class employed women hire domestic workers to perform the household duties that they cannot perform due to their participation in the labour market. Hochschild sees the fundamental solution to resolving this cascade of problems as increasing the value of caring work, so that individuals who are engaged in the work of caring receive more value and credit for doing it. In addition, Hochschild

(2000) and Folbre (2001) argue that the participation of men in caring work needs to be increased.

Extending this concept of global care chains, Irish feminist sociologist Nicola Yeates (2005a, 2005b) developed the idea of the global care economy. Interested in the transnational migration of Philippine domestic workers and the role of the state, Yeates (2009) argued that the concept of global care chains provides a “productive framework for analyzing the relationship between capitalist dynamism and the mobility of reproductive labour” (p.176). Yeates provides insight into how women from third world countries migrate to developed countries to provide social care services due to the commodification and commercialization of care. Moral concern over global care chains and the “globalization of love” frequently relates to the welfare of the children who are left behind (Hochschild, 2000). While Hochschild concentrates on unskilled female labour, Yeates (2005a) broadens the application of this theory to discuss the position of skilled migrants (particularly nurses) in the global care chains. Using a global commodity chain analysis of world systems theory (a macro-level theory that describes the dynamics of global capitalism by dividing the world into core, periphery and semi-periphery countries and examines their inter-relationships and flows of capital and labour), Yeates (2005a) identifies three analytic elements that can be applied to care service: structure of inputs and outputs, territoriality, and governance. The structure of global care chains is characterized by education, recruitment, and organization of services. Territoriality in global care chains is characterized by networks of labour, including domestic workers, employment agencies, and migrant organizations, which operate through informal and formal channels. Global care chains also rely on internal and external governance: internal governance includes power and authority relations among diverse

agents in the care chain, while external governance includes professional regulation, labour regulation, and state control of legal and illegal migration.

According to Yeates (2005b), global care chains not only link people across the globe, but “they also link economic and welfare systems of different levels of ‘development’ and countries occupying different positions in the international political economy” (Yeates, 2005b, p. 230). Hence, women from developing countries migrate to developed countries in order to provide services in the international care economy. This movement of labour results from global, social, and economic inequities, as well as the uneven distribution of material resources. Structured by gender, class, nationality, and ethnicity, the global movement of migrant workers reinforces inequities in the distribution of care resources and reproductive labour.

LEVELS OF ANALYSIS OF GLOBAL CARE CHAINS OF DOMESTIC WORKERS

Like Yeates (2005b), Rhacel Parrenas (2001), an American Filipino feminist sociologist, incorporates the global (or macro) level approach in her description of global care chains. However, Parrenas delves deeper into the particular experience of migrant domestic workers by delineating three levels of analysis (macro level, intermediate level, and subject or micro level). In line with Parrenas’ conception of the three levels of analysis, Williams (2012) distinguishes a micro level that focuses on the day-to-day relationships of care workers and their employers, a intermediate or meso level that focuses on the institutional factors that shape this relationship, and the macro level that focuses on global processes that shape the transnational political economy of care work. Similar to Hochschild’s (2000) and Yeates’ (2005b) ideas, Parrenas states that at all levels of analysis, intersections of race, gender, sexuality, nationality, and class

are at play. In the next section, the three levels of analysis of the concept of Global Care Chains will be discussed using Parrenas framework.

Macro Level Analysis

According to Parrenas, macro level analysis focuses on the macro process and structures and processes that control the flow of migration and the labour market integration of immigrants in destination countries (Parrenas, 2001). Important at this level of analysis is the position of women in global capitalism and feminization of the global labour force; and the functioning of global labour markets, including global economic restructuring, the de-nationalization of economies, and the re-nationalization of politics or growing sentiment of nationalism.

Global capitalism maintains and organizes nations into unequal relations and unequal structural linkages between sending countries and receiving countries (Parrenas, 2001; Sassen, 1997; Williams, 2012). For instance, multinational institutions maintain economic centres in such places in North America such as New York, Los Angeles and Toronto, the rise of which creates a need for low wage labour to maintain the lifestyle of their middle-class populations.

Judith Butler and Gayatri Spivak, feminist theorists, notes that global capitalism originates from imperialism and sustains exploitation (Butler & Spivak, 2007). They argue that the idea of the nation-state inevitably leads to non-citizenship or non-belonging for certain populations, especially migrant populations. Describing the situation among member states comprising the European Union, Butler elaborates on the function of temporary migration:

And of course, one of the bids that the European Union has made to various countries is: Join us and we will help you guard your borders against unwanted

laborers. We will also make sure that you can get those cheap laborers and that they'll come in with less than legal status with temporary contracts and don't worry, your populations won't alter permanently.... We could produce a permanent laboring class for you (Butler & Spivak, 2007, p. 85-86).

Similarly, American feminist political economist Nancy Folbre (2001) in her book, *The Invisible Heart*, stated that the great appeal of temporary foreign workers is their disposability, along with the fact that they require little economic investment and they can be denied certain social benefits, making this pool of workers cost-effective.

Zaman (2006) argues that by keeping wages of migrant labour down, migration facilitates the growth of capitalism. Her analysis of the Live-in Caregiver Program in Canada concludes that through its immigration policies, the welfare state creates structural barriers for immigrants to attain equal opportunities irrespective of their class, race and gender. The result is intensification of the class-based, gendered and racialized labour market. Thus, "the very process of immigration policy defeats the notion of equal opportunity for all immigrants and citizens, irrespective of gender, race and class in a liberal welfare state like Canada" (p. 157).

Sassen (1997) notes that even though more women have become professionals in global corporate activities and international relations, the global economy can still be said to be male gendered, as it has the power dynamics and cultural properties associated with men of power. She argues that what we see in the global economy is the valorization and over-valorization of certain outputs and workers, mostly in male-dominated professions. In the global economy, devalored or low value sectors are where immigrant women predominate, where "immigration and ethnicity are constituted as otherness" (p. 21). The corporate work culture is valued and

other kinds of work cultures are devalued. Hence, global cities render immigrant women invisible, a form of off-shore proletariat.

Intermediate Level Analysis

At the intermediate level analysis, the focus is on institutions and shifts in social processes and social relations, “shaped by the interplay of structures and agency” (Parrenas, 2001, p. 23). The actors include transnational institutions such as hometown associations, families, networks, communities, political groups, and business enterprises. Migrant domestic workers respond to larger structural and global forces by manipulating such institutions, creating migrant communities (through social networks), maintaining migration flows, and by securing social and labour market incorporation upon settlement (Parrenas, 2001). Migrants create transnational institutions to negotiate the stunted integration and settlement opportunities they face in destination countries. By creating transnational institutions such as hometown associations and political activist groups, migrant domestic workers endeavor to counteract their marginal status in destination countries.

Social institutions, however, produce different labour market and family experiences for men and women (Parrenas, 2001). Also important in this level of analysis is gender, as gender ideologies have historically assigned duties to both men and women in both private and public spheres (Pessar, 1999) and institutions are sites of patriarchy (Parrenas, 2001; Pessar, 1999). Anthropologist and feminist transnational migration scholar, Pessar (1999) argues that within transnational institutions, immigrant women extend their role as mothers and as wives. Class, race, and gender are interlocking process that exist in relation to each other and mutually shape power inequality (Hills Collins, 2000). The interpenetrating effects of class, race, gender and

ethnicity characterize the lives of immigrant women, accentuating the triple jeopardy of class, race and gender (Pessar, 1999).

Subject or Micro Level Analysis

It is at the third level of analysis (subject or micro level) that Parrenas (2001) places her prime focus as a starting point to understand the other levels of analysis. This is because the average domestic worker does not define her experiences at the macro level of analysis (including global capitalism), but from her everyday experiences. As opposed to the intermediate level of analysis, which documents social processes, the micro level analysis investigates social process as “settings for the process of subjection” (p. 31). In other words, it is from the social process and the institutional context that the subject position of migrant domestic workers is formed. Hence, the “subject cannot be removed from the external forces that constitute the meanings of their experience” (p. 24). In this way, the subject formation is shaped by the forces of globalization (macro level) and the social process (intermediate level). Moreover, Parrenas argues that it is the “social process that produces discourse” which “refers to a particular system of meanings communicated by language and practices” (p. 31). In turn, this discourse produces the subject position of migrant domestic workers. Discourses are intertwined with power relations, but are not unilateral.

Parrenas (2001) turns to Foucault’s notion of power as a circulatory mechanism and Butler’s analysis of subject formation to explain the micro-level of analysis she applies. In the words of Foucault, “power exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures” (Foucault, 1982, p. 788). In this sense, power is relational. Against this form of power are

immediate struggles (closest instances of power) and attempts to resist domination. Following this line of reasoning, Butler (1997) argues that an analysis of the subject position must both trace the conditions with which it is formed and the resistance against those conditions.

PARRENAS' DISLOCATIONS

Beginning her analysis from the micro or subject level, Parrenas (2001) identifies the experience of domestic workers as occupying multiple subject positions which she refers to as dislocations or “narratives of displacement” (p. 15). Analyzing the subject level from multiple positions and multiple locations of race, class, gender and nationalism is important; several third wave feminists emphasize the importance of accounting for the specific context (or locations) of experiences and avoiding universal notions of gender, class, and race (Mohanty, 1991; Spivak, 2005). Parrenas defines dislocations as “the position into which external forces in society constitutes the subject of migrant Filipina domestic workers” (2001, p. 3). In other words, dislocations are the challenges, pain and stumbling blocks faced by migrant domestic workers while they navigate the social process of migration.

Connecting dislocations to the macro and micro levels of analysis, Parrenas (2001) states: “Dislocations emerge from the positioning of migrant Filipina domestic workers in institutional processes of global restructuring, including the outflow of labour, the formation of transnational households, the emergence of educated women into the secondary transnational tier, and the constitution of disenfranchised migrant communities” (p. 251). By examining these processes, Parrenas analyzes the politics of the incorporation of migrant domestic workers through the lens of four key institutions: the nation-state, the family, the labour market, and the migrant community (p. 4). These dislocations are the experience of being partial citizens, the experience

of contradictory class mobility, the pain of family separation, and the feeling of social exclusion or non-belonging.

However, migrant domestic workers are not only subject to these processes, they also resist and negotiate their dislocations (for instance, through active involvement in advocacy groups). Through such activities, Parrenas argues, migrant domestic workers recreate structural inequalities. This is because “agency is conditioned and therefore limited by the social process from which it emerges and takes place. This means resistance, as it recuperates, does not necessarily bring positive change” (Parrenas, 2001, p. 34). Hence, Parrenas cautions that marginalized women (especially migrant domestic workers) can reconstitute power inequalities in the process of exercising power. Similarly, Constable (2007) argues that domestic workers are participants within the field of power (although not equal players); they “resist oppression in certain ways but also simultaneously participate in their own subordination” (p. 13). Next, the four dislocations experienced by migrant domestic workers as proposed by Parrenas (2001) will be briefly explained.

The Pain of Family Separation

Migrant domestic workers migrate to provide economically for their families (Parrenas, 2001). Hence, these women reconstitute their role in the family as they become the family breadwinner. The international division of reproductive labour among women occurs, according to Parrenas, in a three tier transfer system: “(1) middle- and upper class women in receiving countries, (2) migrant Filipina domestic workers, and (3) Filipina domestic workers in the Philippines who are too poor to migrate” (p. 72). By being in the middle in the division of reproductive labour, Parrenas (2001) argues that migrant Filipinas experience dislocations as

they maintain transnational households and experience family separations. The pain of family separation is great for domestic workers and often leads to emotional distance and detachment in the family. Being in the middle of the tier means that they are or become middle class in the Philippines, but are working class in the destination country, further emphasizing their contradictory class mobility and partial citizenship. In this situation migrant domestic workers can fulfil their parental role of providing materially and financially for their children, but their ability to provide emotionally as parents is limited.

Feeling of Social Exclusion and Non-Belonging

The dislocation of social exclusion and non-belonging as described by Parrenas (2001) is reflected in the constant discomfort experienced by migrant Filipina domestic workers both within their immigrant community and also from the dominant community of the destination country. This dislocation affects their position as well as their attitudes, behavior and feelings in the destination country. Within the migrant community, domestic workers find both collectivism and competition, which means they find support within their community and at the same time experience alienation from that community. For relief from these feelings of non-belonging, migrant domestic workers create spaces of gathering, including churches, bus stops, and train stations to strengthen their social network and personal responsibility in the community.

Contradictory Class Mobility

According to Parrenas (2001), Filipina domestic workers experience a marked dislocation of contradictory class mobility characterized by declining social status and an increase in financial status (Parrenas, 2001). This contradictory class mobility results from the structural

forces that shape globalization as well as global capitalism. Individuals from developing countries with high educational attainment migrate to richer, developed world countries, increasing their income status while simultaneously decreasing their social status. Moreover, their relationship with their employer is characterized by spatial inequality, where there is inequality between employers and domestic workers in their control of space. The consequent emotional tensions are exacerbated by the emotional labour required of domestic workers.

It is often claimed that domestic workers are treated “like one of the family”. Constable (2007) explains this as a form of coercion by employers, using a story line commonly recited by Filipinas in Hong Kong:

A Filipina domestic helper arrives in Hong Kong at the home of her new employer. The employer says to her, ‘We want to treat you as a member of the family.’ The domestic helper is very happy to hear this. On Sunday, the helper’s day off, her employer says to her, ‘You must work before you leave the house on Sundays [the usual day off] because you are a member of the family.’ And the employer adds, “And you must come home in time to cook dinner for the family’ ‘But sir, ma’am, I would like to eat with my friends today, because it is my day off,’ says the helper. ‘But you are a member of the family’ says the employer, ‘and because you are a member of the family you must eat with us’ (p. 112)

Bakan and Stasiulis (1997) argue that the idea of being “like one of the family” perpetuates unequal power relations by clouding the paid labour of domestic work through the use of family ideologies. However, using Foucault’s idea of power relations, Parrenas found that domestic workers can also use the myth of being “like one of the family” to resist inequalities. According to Parrenas, being treated like one of the family enables domestic workers to feel that

their work is humane, especially within the spatial zone of their employers' homes. The home setting itself contributes to the contradictions. Stacey (2011) argues that the spatial zone of home care creates ambivalence for home care aides as to whether the care provided is for money (i.e., they are employees within a market exchange) or for love (i.e., they are kin within a familial economy, not employees but helpers). It appears that being seen as a member of the family (focusing on love) can be helpful to home care aides' self-image and reinforce their job satisfaction.

Partial Citizenship

While Parrenas may not quite agree with Bakan and Stasiulis (1997) on the significance of the idea of being “like one of the family”, their ideas on partial citizenship are congruent. Parrenas (2001) argues that migrant Filipina domestic workers experience partial citizenship due to the contradictions of nationalism in the context of globalization — they are neither fully protected by the Philippine government nor fully integrated in receiving countries. The dislocation experience of Filipina domestic workers is intensified by the denationalization of economies, which creates a demand for low wage labour, and by the renationalization of politics, which prevents them from gaining citizenship rights in the destination country.

Canadian feminist political scientists Abigail Bakan and Daiva Stasiulis note that non-citizenship has become an intrinsic aspect of migrant domestic worker programs and thus conceals the dynamics between citizenship and non-citizenship (Bakan & Stasiulis, 1997). They argue that the citizenship offered to live-in caregivers is partial, provisional or precarious (Stasiulis & Bakan, 2005). Denial of full citizenship increases domestic workers' oppression based on gender and race, intensifies class exploitation, and withholds several human rights.

Migration of foreign domestic workers to Canada has meant a trade-off between third world and first world citizenship. In their attempt to gain citizenship in Canada, migrant domestic workers focus on gaining social rights such as the right to adequate health care, but forfeit civil and political rights. Applying Canadian political philosopher Joseph Carens' argument on rights to support their idea on partial citizenship, Stasiulis and Bakan argue that individuals with partial citizenship seek democratic rights and opportunities for a decent life, just as other members of society do.

CARENS ON RIGHTS OF TEMPORARY WORKERS IN CANADA

In his paper entitled "*Live-in caregivers, seasonal workers and others hard to locate on the map of democracy*", Canadian political scientist Joseph Carens supports the need for a "global sense of ethic" as proposed by Hochschild. He argues that individuals who have lived within a democratic society for a long period of time are *ipso facto* members of the society and are entitled to the same rights and benefits as citizens. He argues that "a democratic society has an obligation to respect the moral and political agency of those who live within it" (Carens, 2005). Many temporary immigrants live in the country of destination for "extended" periods of time and, as a consequence, become familiar with the practices of the destination society. They are expected to abide by the laws and rules of the destination country – an experience that shapes their social world profoundly. Carens argues that if the immigrant is a free moral agent, he or she should have full citizenship, including the right to participate fully in the social, economic and political life of the destination country.

Commenting on the case of live-in caregivers and temporary seasonal workers, Carens (2008) states that "the longer the stay, the stronger the claim to full membership in society and to

the enjoyment of the same rights as citizens, including, eventually, citizenship itself” (p. 1). With respect to family unification, Carens notes that many international documents have recognized the right to family unification. In his view, if states are to abide by these international human rights policies, they should create mechanisms to ensure family unification. The longer a person is separated from her or his family, the higher the degree of violation of this human right. In short, Carens’s argument is that the longer the stay, the greater the right to full citizenship, including the right to bring one’s family.

With respect to economic and social rights, Carens (2008) divides these rights into several areas: working conditions, social programs directly tied to employment, and other social programs. In his view, the working conditions of temporary migrant workers should meet the minimum standards of the receiving country. Moreover, the law of reciprocity is violated when government programs require temporary migrant workers to pay for social programs whose benefits they are ineligible to collect; in Canada, this applies to deductions for the national pension plan employment insurance scheme which temporary migrant workers often contributes to, but do not receive the same benefit from as citizens.

Carens (2008) questions the moral basis for the restriction of temporary migrant workers to particular sectors or occupations. These restrictions are often put in place because the function of temporary migrant workers programs is typically to meet a labour shortfall, often due to the very low wage employers are offering for a particular type of job. In a normal market model, a labour shortage is met with an increase in payment to attract workers; for instance, there are no shortages of garbage collectors as it is a well-paid job. Live-in caregivers, however, despite being expected to have a certain amount of education and training, are paid minimum wage. Of course, if the live-in caregiver wage was increased, more Canadian citizens would be willing to

do this work. Carens argues that if the pay for labour is high enough, there are no jobs for which workers cannot be found; therefore, a persistent shortage of labour implies that employers are unwilling to pay employees the market rate within their nation-state. The moral issue is that of exploitation and unfairness as temporary migrant workers are forced to work under conditions that are worse than if they were free to compete in the labour market of the destination country.

Carens (2008) views the devaluing of care work as a major contributing factor to the issue of justice for live-in caregivers. Similarly, Hochschild (2004) argues that the devaluing of female and caregiving work is the basis for recruiting migrants to do this work. The declining value of care work results from the cultural politics of inequality. Like Carens, Hochschild argues that one solution is to raise the pay for live-in caregivers; another is to encourage the involvement of fathers in care work.

In addition to issues of gender, there are issues of class. Carens argues that the Live-in Caregiver Program exists only because it benefits and serves the interests of the politically influential group, that is, those in power. Carens maintains a conflicted position on whether or not the program should be abolished or not:

On the one hand, I do not think the program meets the standards of justice. On the other hand, its restrictions are limited and it provides an opportunity for a couple of thousand disadvantaged people a year to gain entry to Canada who would otherwise have no chance of admittance. In that sense, its defenders are right that it serves the interest of the workers who are employed within it. (p. 16)

Carens (2008) argues that although states have no obligations towards individuals who do not reside within their borders or obligations to allow temporary workers to migrate, they do have an obligation to ensure that they are treated with the same standard of democratic justice (as

their own citizens) if they choose to admit these workers. In the same light, employers have no moral obligation to hire a domestic worker, but they have moral and legal obligations once they have hired one.

Carens' arguments are congruent with those of the United Nations International Labour Organization. The United Nations International Labour Organization (ILO, 2010) International Labour Conference recognizes that most domestic workers migrate under temporary migration schemes and argues that the wide-spread migration of migrant workers under temporary migration schemes reinforces the idea that domestic workers are invited to work for a family but not for the labour market. The underlying assumption is that temporary migrant workers will use their work experience as temporary migrants to find suitable employment and to apply for permanent residence. Considering that many migrant domestic workers under the temporary migration stream see migration as a step on the socio-economic ladder to fulfilling employment in the destination country, the ILO urges improvement in mechanisms for career development for migrant workers. Similarly, although the United Nations International Convention on the Rights of Migrants Workers makes no mention of the long-term economic obligations towards migrant workers, it recognizes that the state has an obligation to meet the social and economic needs of migrant workers (Office of the United Nations High Commission for Human Rights, 1990). The convention states that "in this respect, due regard shall be paid not only to labour needs and resources, but also to the social, economic, cultural and other needs of migrant workers and members of their families involved, as well as to the consequences of such migration for the communities concerned" (Office of the United Nations High Commission for Human Rights, 1990, Part V1, Article 64.2).

CONCLUSION OF THEORETICAL FRAMEWORK

In conclusion, Hochschild, Parrenas' and Yeates' work on global care chains as well as Carens' perspective on justice provide a useful framework through which to analyze the rights of live-in caregivers and the obligations of the Canadian government. Hochschild's (1983) idea of emotional labour presents a theoretical background for the development of the concept of global care chains, highlighting the unequal distribution of emotion work, based on class and greatly affected by gender. Inequalities among individuals of different gender, class and race positions are further reflected in Hochschild's (2000) notion of global care chains, as reproductive labour is transferred from the North to the South. Within these dynamics and inequalities, Parrenas (2001) argues, migrant domestic workers experience dislocations, including partial citizenship, the pain of family separation, social exclusion and non-belonging, and contradictory class mobility. These dislocations will be used as a starting point in analyzing the experience of live-in caregivers in Canada, especially those who experience a contradictory class position, being professionals in their country of origin and lower status live-in caregivers in Canada. Carens' (2008) application of the law of reciprocity to argue for the socio-economic rights and well-being of individuals who have resided and worked in a country for extended periods of time, will be adopted. The work of these scholars provides a framework for the current study, which investigates the perspectives of diverse stakeholders in the global care chain toward the integration of professional nurses who migrate to Ontario to work as live-in caregivers.

Considering the issues raised by these theorists and scholars, this research aims to shed light on the following research questions:

1. Why do Philippine educated nurses migrate to Ontario through the Live-in Caregiver Program?

2. What are the expectations of Philippine educated nurses who migrate to Ontario through the Live-in Caregiver Program?
3. Do nurses from the Philippines who migrate to Ontario through the Live-in Caregiver Program experience the dislocations of contradictory class mobility, partial citizenship, pain of family separation, and feelings of social exclusion and non-belonging? If so, how do they experience these dislocations, and how do they resist or negotiate these experiences?
4. What are the views of stakeholders on the migration and integration of nurses who migrate through the Live-in Caregiver Program, especially with respect to socio-economic rights and obligations?

CHAPTER 4: METHODOLOGY

INTRODUCTION

This thesis applies a qualitative case study methodology to examine the experience of nurses who migrate to Canada through the Live-in Caregiver Program, and explores the diverse perspectives of policy stakeholders. Case studies can differ widely from single to multiple case studies with varied units of analysis. In what follows, the constitution of the case study will be explained with particular reference to the ideas of Yin (2009) and draw from the ideas of Creswell (1998), Merriam (1988), and Stake (1995). Next, this chapter describes the data collection strategy, as well as issues of quality, reflexivity, ethics and finally, data analysis, as they relate to the study.

CASE STUDY METHODOLOGY

Yin (2009) presented a two-fold technical definition of case study research methodology. The first segment of this definition relates to scope: “a case study is an empirical inquiry that investigates a contemporary phenomenon in depth and within its real life context, especially when the boundaries between phenomenon and context are not clearly evident” (Yin, 2009, p. 18). These contextual influences can include historical, social, geographic and political circumstances (Creswell, 1998). Due to the blurry distinction that frequently exists between phenomenon and context, case studies have been widely used in policy research (Yin, 2009) to uncover its paradoxes and discourses (Greenhalgh et al., 2010; Rouch, et al., 2010; Sheikh, & Porter, 2011). For instance, Yeates (2009) utilized a case study methodology to explore the migration of internationally educated nurses to Ireland, enabling her to consider the contextual influences of transnational migration, and expand the concept of global care chains beyond

domestic worker migration (to nurse migration). The importance of contextual influences has been further emphasized by Creswell (1998) and Merriam (1988). Similarly, Stake (1995) defined case study as “the study of particularity and complexity of a single case, coming to understand its activity within important circumstances” (p. xi).

Stone (1988) argues that since there is complexity in the policy making process, “we must understand analysis in and of politics as strategically crafted argument, designed to create paradoxes and resolve them in a particular direction”. In other words, we must understand the processes and struggles over ideas that shape policies (a highly relevant issue in terms of migration). The analysis of competing ideas lends itself well to the use of multiple data sources and to understanding discourses within the realm of policy decision making.

Case study researchers have consistently emphasized the importance of using multiple sources of data (Merriam, 1988; Stake, 1995; Yin, 2009). The second part of Yin’s definition of case study relates to data collection and data analysis strategies, and results from the uniqueness and fluid boundaries between phenomenon and context. Yin (2009) states that the case study inquiry:

- copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result;
- relies on multiple sources of evidence, with data needing to converge in a triangulating fashion, and as another result;
- benefits from the prior development of theoretical propositions to guide data collection and analysis. (p. 18)

Diverse contextual influences necessitate the use of multiple methods of data collection, including interviews, documents, archival materials, and observations as well as the use of

theoretical propositions. Multiple data sources ensure that the research question is explored through multiple lenses so as to reveal and understand multiple facets of the phenomenon (Baxter & Jack, 2008). Theoretical propositions help to guide the research and also ensure theoretical generalizability of the research findings (Yin, 2009).

Yin (2009) states that “case studies are the preferred method when (a) “how” and “why” questions are being posed, (b) the investigator has little control over events, and (c) the focus is on a contemporary phenomenon within a real-life context” (p. 2). According to Yin (2009), an important component of any case study research design is the unit of analysis which helps to define the actual “case”. Cases are specific, complex functioning and integrated or bounded systems (Creswell, 1998; Merriam, 1988; Stake, 1995) rather than abstract theory, argument, hypothesis or concept (Stake, 1995; Yin, 2009). With respect to a “bounded system”, Creswell (1998) and Yin (2009) note that case studies must be specific to a time and place, including spatial (e.g., geographical location), temporal (time boundaries), and other concrete boundaries. As Merriam (1988) and Yin (2009) note, cases can include decisions, organizations, individuals, processes, neighborhoods, events, institutions or programs (Merriam, 1988; Yin, 2009). The “bounded” nature of case studies (Creswell, 1998), as well as the focus on gaining rich and extensive insight into the real life context of a case (Yin, 2009), makes case studies a widely used methodology in policy research (Lessard, Contrandriopoulous, & Beaulieu, 2009; Squires, 2011; Williams et al., 2010).

Yin (2009) distinguishes four types of case study designs: single case study embedded design, single case study holistic design, multiple case study embedded design, and multiple case study holistic design. The main difference between embedded and holistic design is that embedded design takes into consideration subunits of analysis (in addition to having unit(s) of

analysis) while holistic design has only unit(s) of analysis. Although multiple case studies can provide a more robust result, Yin (2009) notes that typical, rare, critical or revelatory phenomena are more likely to require a single case study methodology. For instance, a typical single case study aims to capture commonplace circumstances or conditions, and can provide useful information on the experience of the average person, program, or institution. Moreover, Creswell (1998) explained that having more than one case may dilute the overall analysis. He states, “the more cases an individual studies, the greater the lack of depth in any single case” because multiple cases can “dilute the overall analysis” (Creswell, 1998, p. 63).

DATA COLLECTION AND UNIT OF ANALYSIS

This study utilizes a single typical holistic case study research design of Philippine educated nurses who migrate to Ontario through the Live-in Caregiver Program as well as critical discourse analysis. According to Yin (2009), one of the rationales for using a single case is that the case is a typical case; by this he means a representative case that captures a predominant circumstance, situation, or condition. This case study takes a typical case approach because more than 85 percent of live-in caregivers are from the Philippines (Kelly et al., 2009), and around half of individuals who migrate to Canada through the Live-in Caregiver Program settle in Ontario (CIC, 2010). Therefore, by focusing on Ontario, the case includes a significant percentage of live-in caregivers in Canada. The inclusion of other regional cases (e.g. Alberta, British Columbia) might distract from (analytic) depth in the research process (Creswell, 1998) due to differences in nursing policies across Canadian provinces.

Initially, the study was designed to utilize an embedded unit of analysis based on the stage in the migration process. The four subunits of analysis originally chosen for this study were:

1. Pre-migration, with a baccalaureate in nursing degree from the Philippines;
2. Post-migration, currently working as a live-in caregiver, with a baccalaureate in nursing degree from the Philippines;
3. Post-migration, completed the Live-in Caregiver Program, with a baccalaureate in nursing degree from the Philippines, and not working as a nurse;
4. Post-migration, completed the Live-in Caregiver Program, with a baccalaureate in nursing degree from the Philippines, and currently working as a nurse.

However, in December 2011, major changes to the Live-in Caregiver Program allowed faster processing of open work permits for live-in caregivers — live-in caregivers could receive their open work permit 18 months sooner on completion of the Live-in Caregiver Program (CIC, 2011a). More than 10,000 live-in caregivers received open permits in the month of December 2011, and many more in the following months (Brazao & Brennan, 2011, December 15). These policy changes narrowed the pool of nurses who were still currently under the Live-in Caregiver Program and increased the percentage of nurses who had received an open work permit (but were not yet permanent residents in Canada). This obscured the subunits of the embedded units of analysis; therefore, the study was changed to a single holistic case study design rather than a single embedded case study design.

There are several possible units of analysis in this study. In its study on migrant Filipino domestic workers in the province of British Columbia, the Philippine Women Centre (2000) identified several relevant variables including sex, age, marital status, level of education, region

of origin, work experience, and immigration status. Similarly, variables considered in Parrenas' (2001) study include type of domestic work, age, marital status, region of origin, legal status, duration of settlement, and educational attainment. Any of these variables could be used as a guide in defining the unit of analysis. The unit of analysis chosen for this study is nurses educated in the Philippines who migrated to Ontario (Canada) through the Live-in Caregiver Program after the year 1992. This temporal boundary was chosen because the Foreign Domestic Worker Program was converted to the Live-in Caregiver Program in 1992, with major changes to the program. Although the temporal boundary of the study included those who migrate to Canada after the year 1992, all live-in caregiver participants in this study migrated between the year 2001 and 2011. The spatial boundary of Ontario was chosen because the greatest numbers of live-in caregivers settle in Ontario. Only individuals with more than two years of nursing education were included to ensure that the participants were sufficiently qualified to apply for registration as Registered Nurses or Registered Practical Nurses in Ontario. Drawing from this unit of analysis as defined, the inclusion criteria for this study included:

- 1) internationally educated nurse (i.e., received nursing education outside of Canada);
- 2) completed a minimum of two years nursing education in the Philippines;
- 3) migrated to Canada through the Live-in Caregiver Program; and
- 4) current residence in Ontario.

Although the study required a minimum of two years of nursing education earned in the Philippines, all internationally educated nurses who participated in this study had at least a four year baccalaureate degree earned in the Philippines. Although the study did not exclude males from participating in the study, all participants in this study were female since no male nurse who migrated to Canada through the Live-in Caregiver Program agreed to participate in this

study⁹. Of the nineteen individuals who contacted the researcher about participating in this study, in response to newspaper advertisements, only two were males. The lack of representation of males in this study is consistent with the demographics of live-in caregivers in Canada — 95 percent of live-in caregivers are females (Kelly et al., 2011).

DATA SOURCES

This study involved three data sources: document analysis; interviews with Philippine educated nurses who migrated to Ontario through the Live-in Caregiver Program; and interviews with key stakeholders. The data sources are described further below.

Data Source 1: Document Analysis

Data Source 1 consisted of document review and analysis. Merriam (1988) and Yin (2009) identify numerous potential sources of qualitative data including public records, popular media, and personal documents. Documents that were reviewed and analyzed for this study are listed in Appendix A. Key sources included Citizenship and Immigration Canada news releases, live-in caregiver discussion forums, the College of Nurses of Ontario website, and petition sites created by live-in caregivers and employers. All documents were obtained from open online sources. According to the Canadian Institute of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Science and Humanities Research Council of Canada (2010) Tri Council Policy Statement, a Research Ethics Board review is not necessary

⁹ Two male nurses contacted the researcher after reading about the study in the newspaper. One was a Philippine educated physician and thus did not qualify for the study. The other had contacted the researcher because he thought the newspaper advertisement was for an educational program, rather than research.

for studies based on publicly available information, including Internet materials with uncontrolled access.

As stated by Simons (2009), document analysis can be a useful precursor to provide information to be explored in subsequent interviews, and helps to provide context (especially in policy analysis) for the interpretation of findings. Document analysis of Citizenship and Immigration Canada news releases and the Minister's speaking notes and the content of a live-in caregiver discussion forum (www.canadavisa.com) was completed before interviews with live-in caregivers and stakeholders were conducted. Yin (2009) notes that documents are also important to augment or corroborate evidence from other sources, such as interviews. Additional documents were reviewed and analyzed to corroborate and support or refute evidence obtained from the interviews. These documents included: information from online petition sites created by live-in caregivers and employers, and information on the College of Nurses of Ontario regarding entry into practice requirements. During the period of data collection, in June 2012, the Federal Skilled Worker Program was temporarily suspended while being reviewed (CIC, 2012). Shortly after the suspension, the number of postings from nurses who wanted to migrate to Canada through the Live-in Caregiver Program increased. For this reason, a second review and analysis of content on the canadavisa.com immigration forum was conducted.

Miller and Alvarado (2005) explain that documents are produced after the writer has considered the message, style, audience and the purpose. The pattern of text (especially in policy) represents its discursive elements and makes critical discourse analysis a relevant analytic strategy. Fairclough (2001) stated that "discourses are diverse representations of social life which are inherently positioned — differently positioned social actors 'see' and represent social life in different ways, different discourses" (p. 2). This means that the lives of

marginalized individuals are represented through different discourses in the government's social practices, and the discourse within each of these practices corresponds to the social positions of actors. Hence, critical discourse analysis provides insight into how elite groups enact, legitimize and reproduce relations of dominance, and sheds light on the properties, structures and strategies that reproduce power relations (Van Dijk, 1993). Discourses are represented in text and language (Fairclough, 2005). Fairclough emphasizes the intertextuality of text; texts are always in relationship and dialogue with one another (Fairclough, 2001). Similarly, elements of social life (including cultural values, social identities, social relations, language, consciousness, and means of text production) are dialectical, each internalizing each other but without being limited or reducible to it. Critical discourse analysis uncovers this dialectical relationship as well as the diverse ways discourses are ordered, including issues of dominance and power. In this study, discourse analysis of text provided insights into how diverse policy stakeholders enact, legitimize, reproduce and negotiate power relations through text and talk.

Data Source 2: Live-in Caregiver Interviews

Data Source 2 was comprised of in-depth interviews with fifteen nurses who migrated to Canada through the Live-in Caregiver Program. Attempts were made to conduct all these interviews before interviewing stakeholders to ensure the study was grounded from the standpoint of live-in caregivers.

Live-in Caregiver Recruitment:

Sandelowski (1995) identified that a qualitative study could have as little as ten participants. Yin (2009) notes that the larger the number of participants one can study the better.

However, Sandelowski (1995) cautions against having a sample that is too large as it may prevent from achieving deep case oriented analysis because “qualitative analysis is generically about maximizing understanding of the one in all of its diversity; it is case oriented, not variable oriented” (p. 180). Sandelowski (1995) also advised that too small a sample will prevent gaining new and richly textured understanding of the phenomenon under study. Therefore sample size should be determined by data saturation. Data collection stopped when data saturation was reached, when there were no new emerging codes. This process is described below in the data analysis section.

Maxwell (2006) points out that when selecting participants for a study, it is important to “consider which kind of informant is important, and, from there, which other people should be interviewed” (p. 87), advice followed in selecting participants for this study. Criterion-based sampling is a form of purposive sampling wherein participants are selected based on predetermined criterion (Maxwell, 2006), in this case based on the inclusion criteria described above. Efforts were made to select participants who could provide rich information about the experience of nurses migrating to Canada as live-in caregivers. In addition to criterion sampling, this study also utilized snowball sampling, a useful sampling procedure for reaching hard-to-locate individuals (Cresswell, 2013), especially immigrant populations (Ogilvie, Burgess-Pinto & Caufield, 2008). Once initial participants suggested names of others to include in the study, the researcher selected participants based on the pre-identified criteria.

Invitations to participate in the study were advertised in the Balita and the Philippine Reporter newspapers (See Appendix B for advertisement flyer) as well as online with facebook support groups for live-in caregivers, a live-in caregiver discussion forum (www.canadavisa.com), and a nursing discussion forum (www.allnurses.com). The study was

advertised bi-weekly in the Philippine Reporter newspaper and Balita newspaper over a period of three months. The diverse recruitment channels were utilized in an effort to ensure a diverse sample of live-in caregivers. In total, nineteen live-in caregivers contacted the researcher in response to the newspaper advertisements; all but five of them were under the impression that the advertisement was for an educational program to assist them in becoming nurses in Canada. Of these nineteen respondents, ten met the eligibility criteria for the study, but only two of these participants agreed to take part in the study. Respondents who did not qualify for the study were other types of health professionals from the Philippines (such as doctors, not nurses), one who was not fluent in English, and nurses trained after arriving in Canada.

An additional ten participants were recruited through a live-in caregiver educational support group for nurses in Ontario; one participant was referred from a live-in caregiver social support group; and three participants were recruited from an informal network. After discussing the study and selection criteria with the coordinator of the nursing educational support group, the researcher was introduced to six nurses who migrated to Canada through the Live-in Caregiver Program. Five of these participants agreed to participate in the study. Shortly after being interviewed, one study participant introduced the researcher to three nurses who migrated to Canada through the Live-in Caregiver Program who later participated in the study. Another participant introduced the researcher to two nurses who migrated through the Live-in Caregiver Program who later participated in the study.

Sixteen participants completed the demographic profile form, but only fourteen of these individuals were interviewed for this study. Efforts were made to contact the other two participants but the researcher was unable to reach them after multiple attempts. During the data collection process one individual posted a thirteen-page unsolicited description of her experience

migrating from the Philippines to Canada through the Live-in Caregiver Program on an open discussion forum (www.canadavisa.com) where the study had been advertised. This account is included as part of the research data as it addresses the interview questions. An interview conducted with a live-in caregiver during a pilot study by the researcher is included in the analysis. This participant did not complete a demographic profile. Hence in total, sixteen completed the demographic profile and fifteen nurses who migrated to Canada through the Live-in Caregiver Program were interviewed.

Attempts to recruit nurses planning to migrate through the Live-in Caregiver Program were made by advertisements on Internet websites, including loonlounge.com, canadavisa.com, as well as live-in caregiver Facebook pages, all sites popular with potential live-in caregivers. Nurses who advertised on the Internet that they wanted to migrate to Canada through the Live-in Caregiver Program were contacted for recruitment purposes. In total, 40 nurses who advertised on an online website their intention to migrate to Canada through the Live-in Caregiver Program over the previous year (August 2011 to July 2012) were contacted to participate in this study. One participant indicated interest in participating, but later declined. Thus, recruiting nurses pre-migration was pursued, but none agreed to participate in the study, perhaps due to their vulnerable status as potential immigrants to Canada.

Live-in Caregiver Interview Procedure:

Once participants contacted the researcher, they were interviewed at a time and location that was convenient for the participants. Based on the schedules of live-in caregivers, most interviews were conducted on the weekend. Participants chose the interview location. Nine interviews were conducted in the “weekend homes” of the live-in caregivers; the other

interviews were conducted in a coffee shop, the University of Toronto, by telephone, and at the workplace of participants (who were working in professional jobs). “Weekend homes” are normally a one- or two-bedroom apartment that accommodates about six live-in caregivers who reside there only during the weekend (See Chapter 7, Part A for a description on weekend homes). Although all the interviews were conducted individually, the first nine interviews were conducted with someone else in the room, as arranged by the participants. Three groups of interviews were conducted consecutively in weekend homes: interviews with Amy, Bridget and Christine (the first three nurses); interviews with Danielle and Emily (nurse four and five); interviews with Francisca, Grace, Helen (nurse six, seven, and eight).¹⁰ Irene (nurse nine) had a friend (who was a live-in caregiver) present during her interview at a coffee shop (the friend was not a nurse and nor a participant in the study). After informed consent had been obtained and participants had completed the demographic profile (See Appendix D), individual interviews were conducted.

All the participants interviewed for this study had completed a four-year baccalaureate degree in nursing at either a college or a university in the Philippines (a complete and summarized demographic profile is presented in Appendix D). As stated above, all the participants arrived in Canada between the year 2001 and 2011. Most (14 of 15) of the participants had worked in another country outside the Philippines before migrating to Canada through the Live-in Caregiver Program). As previously noted, the major source country pre-arrival in Canada was Saudi Arabia. Of the fifteen participants interviewed, eleven had worked in Saudi Arabia. The participants had various nursing specialties prior to arriving in Canada, including neonatal intensive care, medical surgical, nephrology, emergency room, post

¹⁰ Pseudonyms (i.e., fake names) are used for the live-in caregivers interviewed.

anaesthesia, psychiatric, paediatric haematology oncology, public health, intensive care, paediatrics, community health and supervisory roles.

Yin (2009) notes that to be an effective case study researcher, it is important to ask good questions, be a good listener, be adaptive and flexible, have a firm grasp of the issues being studied, and be unbiased by preconceived notions (by being sensitive to contradictory evidence). Yin (2009) further states that: “research is about questions and not necessarily about answers” (p. 70). According to Maxwell (2006), a research question should formulate what a researcher wants to understand, while the interview questions are those the researcher will use to gain an understanding of the study subject. The researcher does not conceal the research question but anticipates as best as possible how people will understand a particular question and how they are likely to respond to it. Yin (2009) notes that interview questions are for the interviewer to think about during the data collection process: “The protocol questions, in essence, are your reminders regarding information that needs to be collected” (p. 86). Appendix E lists the initial interview questions. In line with Yin’s (2009) advice, these questions shaped the semi-structured interview process and provided points for the researcher to think about to ensure that the required information was collected from live-in caregivers. Furthermore, in line with qualitative methodology, this study utilized an emergent design, a design where participant selection and interview questions are modified as the research progresses based on information obtained from participants (Cresswell, 2013). Interview questions posed to participants were modified as data was collected. This ensured the researcher was able to gain an in-depth perspective into the experience of this group of nurses. The participants were asked about their immigration experience, nursing registration experience, and experience as live-in caregivers. After completing the demographic profile, the interviews lasted approximately one hour, were audio-

recorded and later transcribed verbatim. At the end of the interview, participants were given an opportunity to debrief.

Data Source 3: Interviews with Canadian Key Stakeholders

In line with an iterative data collection plan, data obtained from the document review and the interviews with nurses who migrate as live-in caregivers assisted in refining the questions for in-depth interviews with policy stakeholders. The selection of policy stakeholders was based on Yeates' (2005) delineation of the actors in global care chains. External governance as it relates to the Live-in Caregiver Program includes labour regulators (e.g., Human Resource and Skills Development Canada), immigration regulators (e.g., Citizenship and Immigration Canada), and nursing regulatory bodies (e.g., College of Nurses of Ontario).

The stakeholders interviewed for this study included an immigration policy maker, representatives from two live-in caregiver recruiter and employer groups, four representatives of institutions that provide educational services to internationally educated nurses (including live-in caregivers), as well as representatives of two live-in caregiver support and advocacy groups. The researcher attempted to interview nursing policy makers, but the nursing regulatory body contacted did not agree to be interviewed. Live-in caregiver recruiters were identified from Internet searches and the yellow pages. In total, 21 recruiters were contacted to participate in the study. Two recruiters who were representatives of a recruiter and employer group organization participated in this study.

Interviews with stakeholders lasted approximately 45 minutes. All nine interviews (with the exception of one interview with an immigration policy maker) were tape-recorded. The initial interview questions for policy stakeholders are listed in Appendix E; these interview questions

were refined subsequent to the live-in caregiver interviews. According to Hammersley and Atkinson (2007), “not only may what is said at one point in an interview be influenced by the interviewees interpretation of what has been said earlier and what might be asked later, but also it is affected by what has happened to the person prior to the interview and what is anticipated in the near future” (p. 180). Remaining mindful of this phenomenon, and considering the political context of live-in caregivers in Canada, the researcher stayed updated on recent news related to live-in caregivers. The researcher also asked participants to share their views on recent developments or activities related to the Live-in Caregiver Program. Interviews with stakeholders were conducted at a time and place that was convenient for the research participants. Three interviews were conducted over the telephone, one interview was conducted at the University of Toronto, and five interviews were conducted at the workplace of stakeholders. All interviews were audio-taped, transcribed verbatim and analyzed.

QUALITY IN QUALITATIVE CASE STUDY RESEARCH

According to Yin (2009), four critical conditions must be considered to maximize the quality of case study: internal validity, construct validity, reliability and external validity. The concepts of validity and reliability as used by Yin (2009) represent a positivist orientation to case study research as it seeks to grasp a singular reality. Furthermore, several authors have argued against the use of positivist criteria (such as validity and reliability) in judging rigour in qualitative research (Emden & Sandelowski, 1998; Lincoln, 1995). As Guba and Lincoln (1994) described, the major issue lies on the underlying epistemological and ontological foundations of the positivist paradigm versus the critical theory paradigm. Contrary to a positivist orientation of a singular reality, this study’s theoretical foundation is based on transnational feminist theory

(specifically the concept of global care chains), which is situated within a critical theory paradigm.

According to Guba and Lincoln (1994), epistemologically, the critical theory paradigm sees knowledge as being value-mediated, with the value of the investigator influencing the inquiry. This calls for the need to continually examine the researcher's positionality and for reflexive engagement in the field. Reflexivity and positionality will be described in the next section of this chapter as well as in the next chapter. Given the ontological position of the critical theory paradigm on historical realism¹¹, in establishing criteria for rigour within the critical social paradigm, Guba and Lincoln (1994) argue that the historical situatedness of the inquiry (i.e., the extent to which the inquiry takes into consideration the social, cultural, ethnic, gender and economic context) needs to be foregrounded.

Congruent with Lincoln and Guba's focus on the need to situate the inquiry within a theoretical paradigm, Yin (2009) proposes the use of theoretical proposition in ensuring quality in case study research. Theoretical propositions that were used in this study are derived from transnational feminist theory which considers the historically-situated interlocking identities of gender, race, and class. These issues are considered throughout the research process, including data collection and analysis. The main theoretical propositions are based on Hochschild's ideas on global care chains and Parrenas' (2001) views on dislocations: the experience of contradictory class mobility, the pain of family separation, the experience of being partial citizens, and the feeling of social exclusion or non-belonging. Embedded within these dislocations are issues of

¹¹ Historical realism implies that there is a virtual reality which is shaped by ethnic, economic, gender, social, political, and cultural values which are crystalized over time (Lincoln and Guba, 2005). In simpler terms, what we currently know as reality is shaped by historical consequences of these aforementioned values (e.g., cultural, social, and economic).

gender, race, and class. As will be described later in the data analysis section, these dislocations were used as the preliminary platform for data analysis.

Another criterion for quality under this paradigm, as described by Guba and Lincoln (1994; 2005), is the extent to which the inquiry provides a stimulus for action. As will be discussed in the next chapter, this research arose out of the dedication to issues of voice and creating channels for agency (Spivak, 2005) for nurses who migrate to Ontario through the Live-in Caregiver Program. To attend to issues of voice as described by Lincoln (1995) and to ensure the study is a stimulus for action, a brief research report has been prepared (see Appendix F) for distribution to all the interviewed stakeholders (including live-in caregivers and policy makers) upon defense of this doctoral dissertation, to provide a platform for collective action.

Morrow (2005) argues that in addition to ensuring that a study is well-grounded in the specific research paradigm, it is also important to consider criteria for trustworthiness that span qualitative research. Authors on case study methodology agree on the importance of utilizing multiple data sources to strengthen the credibility of case studies (Merriam, 1988; Stake, 1995; Yin, 2009). As previously stated, the data sources for this study included documents and interviews with nurses who migrated through the Live-in Caregiver Program and stakeholders (immigration policy makers, nursing policy makers, recruiters, nurse educators, and support group representatives). Next, issues of reflexivity and positionality will be discussed.

POSITIONALITY AND REFLEXIVITY

I paid close attention to issues of positionality and reflexivity. Research reflexivity is the “researcher’s engagement with her own positioning in relation to the world she is researching, and or the self-conscious writing up of research as itself an act of representation” (Gray, 2008, p.

936). Positionality refers to the position the researcher occupies in the knowledge development process (Finlay, 2002). Insider/outsider roles are an important aspect of positionality. Moreover, positionality is a fundamental aspect of Parrenas' (2001) idea of dislocations because reality is co-constructed between the researcher and the participant. Hence, the researcher is a tool in the research (Guba and Lincoln, 2005). The "researcher openly acknowledges tensions arising from different social positions in relation to such factors as class, gender, and race" (Finlay, 2002, 535). In considering positionality, the researcher must be conscious of the power relationship between her and the research participants. Researchers must consider how they influence the process of the research in all aspects of the qualitative research inquiry (Speziale & Carpenter, 2007) by having conscious and thoughtful self-awareness of issues of power, class, race, gender, etc. (Finlay, 2002). In being reflexive, the researcher must continually consider her own positionality, her biographical relationship to the topic and the multiple voices in the text as well as attend to emotions.

In actively exercising reflexivity, I kept a self-reflexive memo (Morrow, 2005) that included a record of my ongoing experiences, reactions and emerging awareness of any assumptions. As discussed by Charmaz (2006), "memo-writing provides a space to become actively engaged in your material, to develop your ideas, and to fine tune your subsequent data gathering" (p.72). In this way, Miles and Huberman (1994) note, "they tie together different pieces of data into a recognizable cluster" (p. 72). They are written to describe puzzling findings while engaged in data collection, to propose a new pattern of data, and to assist the researcher to clarify a concept (Miles & Huberman, 1994). Also, as a tool, the use of memos assists me to continually reflect on the data as well as to reflexively examine my positionality as a researcher. This form of journal entry enabled me to critically reflect, acknowledge and recognize the effects

I have on the research as well as the influence of the research on me (Allen, 2004). Using a reflexive memo, I examined my views about nurses migrating to Canada as live-in caregivers, my experiences in the field, and the influences of my biologic position (including race and gender on the research process). This activity assisted in de-centering myself as an expert in the field and to consider how I and participants co-construct reality. The next chapter provides an in-depth analysis of my reflexive engagement in the field.

RESEARCH ETHICS

Ethics approval to conduct this study was obtained from the University of Toronto Health Science Research Ethics Board. This study abides by the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2)* (CIHR, SSHRC, & NSERC, 2010).

Informed Consent

As stated above, live-in caregivers were recruited through various means, including educational institutions and newspaper advertisements. Interested live-in caregiver participants contacted the researcher either by telephone or email, and the researcher sent an information letter and consent form by email to those participants who provided an email address or at the beginning of the interview. Policy stakeholders were contacted by phone or email to participate in the study. The email message included a copy of the information letter and consent form (see Appendix B for information letter and Appendix C for consent forms). One recruiter and one support group representative found information on the study through the study Facebook site and contacted the researcher. Subsequently, an information letter and consent form was sent to these participants. All interested participants were invited for an interview at a time and place of their

convenience. Participants were provided with an informed consent form prior to the beginning of the interview and were given time to read and ask questions about it before signing. The researcher answered all questions the participants had about the study to their satisfaction.

Establishing trust is very important, especially in marginalized populations (Haverkamp, 2005; Ramcharan & Cutcliffe, 2001). To build trust, expectations were explored before the interview. Information in the consent form included the purpose of the research (including the research questions), eligibility criteria, procedure, potential benefit, potential risk, research procedure, confidentiality, right to refuse to participate in the study, and right to withdraw from participation in the study at any stage in the research procedure. Consent was renegotiated throughout the research process (Morse, Niehaus, Varnhagen, Austin & McIntosh, 2008).

Confidentiality and Anonymity

Efforts were made to ensure the highest level of confidentiality. Access to interview data was available only to the research team, including the doctoral candidate and the supervisory committee. The name and identity of the research participants were kept confidential. Participants were informed that any publications, reports or presentations will not include any of the participant's names or identifiable data and that a pseudonym will be used in dissemination of the study results. All printed materials, flash drives, and audio materials are being and will be kept in a secured filing cabinet at the University of Toronto for a period of seven years and will then be destroyed. The consent forms were also secured and locked in a separate filing cabinet from the data. All data analysis completed by computer was stored in a password- and firewall-protected hard drive and encrypted. Hard copy documents for the study will be destroyed by shredding and audio records will be deleted after a period of seven years.

Many of the individuals interviewed are in the process of trying to become permanent immigrants in Canada. Hence, high priority was given to the issue of anonymity and pseudonyms are used in the presentation of findings. To further ensure confidentiality and anonymity, a single case study was used rather than the use of individual live-in caregiver as units or subunits of analysis, and pairs of recruiter or employer and live-in caregiver were not interviewed. That is, if a recruiter or employer was interviewed, no live-in caregiver was recruited from that particular agency or employment relationship.

Risks and Benefits

The level of risk posed by participating in this research was minimal. However, migrating through the Live-in Caregiver Program, going through the registration process, and being marginalized may pose a crisis for participants. Individuals who have not had time to process or resolve a crisis or who have experienced psychic trauma may be highly emotional, and participants may not be aware of upsetting memories until they start discussing them (Morse, Niehaus, Varnhagen, Austin & McIntosh, 2008). Hence, ethically important moments may occur during the research (Guillemin & Gillam, 2004). During the interviews, the interviewer was sensitive to the psychological and emotional needs of the research participants. For instance, Danielle and Emily cried during the interview process due to the emotional trauma Danielle experienced while she was working as a live-in caregiver. The interviewer offered to stop the interview but both participants wanted the interview to continue as it was an opportunity for Danielle to verbalize her feelings and have someone to simply listen to her. Danielle was provided with information for counseling services. However it was evident from her response

that she had no plan to utilize the services. Instead she hoped to rely on going to church for her emotional healing.

While there may be benefits for some participants to tell their stories, it was important before the research to inform participants (especially those currently in Canada) that they may not get any benefit from participating. However, participants were made aware of the potential contributions of the study to the socio-economic well-being of internationally educated nurses and live-in caregivers in Canada by informing immigration and nursing policy. Also, it was important to clarify and maintain boundaries in the research, and the role of the researcher (Dickson-Swift, James, Kippen & Liamputtong, 2006). When individuals inquired about the study, the researcher emphasized that the purpose of the research was to gain knowledge on the experience of live-in caregivers, not offer assistance to become a nurse in Canada. This was important to clarify as some who contacted the researcher thought the research could help them in this way. In response to this, the recruitment flyer was refined (see Appendix B for both recruitment flyers) to make the research purpose more clear.

Compensation

All participants who agreed to participate in the study were offered a \$20 gift certificate as a sign of appreciation for their time and contribution.

Conflict of Interest

The researcher made reasonable efforts to ensure a neutral position in the field. Since there were competing views from participants, the researcher made efforts to not have a strong

affiliation with any of the stakeholder groups involved in the migration of nurses to Canada through the Live-in Caregiver Program.

DATA ANALYSIS

Data analysis occurred simultaneously with data gathering and involved a reflexive analysis of the data (Merriam, 1988). The first interviews were transcribed verbatim. In simultaneously performing data gathering with data analysis, linkages were made between the data and between the questions to have a more critical look at my data (Charmaz, 2006), including rival explanations (Yin, 2009). The researcher read the transcribed data a couple of times as well as the memo to get a sense of the data. Reading the transcribed data several times, the researcher made linkages between the interview data as well as between the data and the reflexive notes. Data analysis was aided by the use of the NVIVO 10 qualitative data analysis software.

Yin (2009) describes four analytical strategies: relying on theoretical propositions, developing a case description, using both qualitative and quantitative data, and examining rival explanations. Two of these strategies, theoretical propositions and examining rival explanations were used in this study. Parrenas (2001) theorized that social processes produce discourse which in turn produces the subject formation of migrant domestic workers. By utilizing a critical discourse analysis strategy, this research explored the dislocations experienced by nurses who migrate as migrant domestic workers to Canada. Case study research methodology and discourse analysis have been used in a similar study that explored struggles over the human rights issues of domestic workers by activist groups in Malaysia (Elias, 2008). Moreover, several researchers have utilized discourse analysis to tackle research questions regarding health human resource

(Mitchell, 2009; Turner, Keyzer, & Rudge, 2007) and health policies (Flood & Chen, 2011; Reiger, 2011).

Van Dijk (2001) stated that critical discourse analysis “primarily studies the way social power abuse, dominance and inequality are enacted, reproduced and resisted by text and talk in the social and political context” (p. 352). Fairclough (2001) identified three levels of analysis: analysis of language text, analysis of discourse practices, and analysis of discursive events as instances of socio-cultural practices. At the first level, analysis of text, the focus is on the use of language by different stakeholders or actors in different context (Alvesson & Skoldberg, 2000). At the second level, the focus is on the values, ideas, beliefs, meaning, conceptions and fantasies in the text or during the interview process. At the third level, the focus is on the analysis of social relations, social behaviors, events, social patterns and social structures.

While going through all these levels of analysis, Parrenas’ ideas on dislocation, specifically contradictory class mobility, the experience of partial citizenship, the pain of family separation, and the feeling of social exclusion or non-belonging, were used as theoretical propositions in guiding the analysis. Moreover, attention was paid to vital concepts by Hochschild on global care chains including the intersection effect of gender, class, nationality, and race on the experience of migrant domestic workers in Canada as well as the concept of emotional imperialism (as described by Hochschild, 2004), emotional labour (as described by Hochschild, 1983) and the law of reciprocity (as described by Carens, 2008).

In considering rival hypotheses, Yin (2009) explained that the initial theoretical propositions might have contained rival hypothesis and may provide more in-depth perspective on the topic under study. For instance, rival hypothesis used in this study relates to discussion by theorists on global care chains related to belonging versus non-belonging. Theorists on global

care chains have argued whether live-in caregivers should be considered “one of the family” or if they should be considered strictly as employers. As discussed in the theoretical section of this proposal, while Bakan and Stasiulis (1997) theorize that the idea of being “like one of the family” perpetuates unequal power relations between employers and domestic workers, Parrenas (2001) notes that the domestic workers sometimes use this myth to resist inequalities. Also, in considering rival hypotheses, the use of negative cases helped to provide competing hypothesis and insight into the motivations for the migration of nurses to Canada through the Live-in Caregiver Program. For instance, several live-in caregivers described their migration to Canada as motivated mainly to gain citizenship for the family. The rival hypothesis that nurses were not migrating to gain citizenship for the family was tested by interviewing nurses who had no family that they could sponsor to Canada. However, as would be fully described later, the use of this rival hypothesis helped to confirm that citizenship for the family is a major reason for the migration of nurses to Canada through the Live-in Caregiver Program. These rival viewpoints enriched analysis of the data on the experiences of nurses who migrate to Canada through the Live-in Caregiver Program.

In addition, divergent perspectives (such as on obligations) revealed by stakeholders, live-in caregivers, and documents were analyzed. These rival explanations provided a more in-depth perspective into the phenomenon being studied and the multiplicity of reality. Yin (2009) explained that a strategy to avoid bias by considering contradictory evidence or rival explanations, is to report study findings to two or three critical colleagues who can offer alternative explanations and suggestions for data collection and analysis. Throughout the data collection and analysis process, the researcher met with her supervisor every month and with her doctoral committee members (three members) every three to six months. The questions posed by

them and their opposing explanations helped to provide a critical insight into the analytical process.

Combining views on the global care chain, NVIVO 10 was used to categorize the data. All the data gathered (including interviews and documents) were imported into NVIVO for analysis and coded. First, the researcher read all the data to gain familiarity. Categorization of the data was initially based on the research questions: the reasons nurses give for migrating to Canada through the Live-in Caregiver Program, their expectations, their experience, and the obligations of stakeholders. Before analysis began, four categories were developed in relation to the experience of this group of nurses in Canada: Contradictory Class Mobility, Partial Citizenship, Pain of Family Separation, and Feelings of Social Exclusion and Non-belonging. These categories are based on theoretical propositions as posited by Parrenas (2001). In the course of data analysis, another code was added, the employer-employee relationship, as several ideas were coming up under this theme. Under the obligations of stakeholder, codes were divided into the obligations of caregivers, immigration policy makers, nursing policy makers, support groups, recruiters, and employers, as well as the rights of live-in caregivers.

As analysis proceeded, each of these codes was expanded with the addition of sub-codes which was guided by theoretical propositions. Codes were further refined by collapsing and reorganizing them based on the data. This process of coding occurred simultaneously with data collection. At the end of ten interviews with caregivers, a total of 67 codes were grouped as stated above. No new codes were added after interviewing the eleventh to fourteenth participant. Moreover, interviews with the twelfth to fourteenth participant yielded no new information within the already established codes. This signified the saturation of data, and recruitment of caregivers ceased as data saturation had been achieved. Stakeholder interviews and document

analysis continued to provide more data to answer the research questions. While there were plans to analyze Filipina newspaper content at the conception of the study, after stakeholder interviews were conducted, and analysis of Facebook, Citizenship and Immigration Canada data webpage and review of the Filipino newspapers, it was decided that such analysis was unnecessary as it yielded no new information.

Since writing is a major aspect of the research process, the codes were read before the writing stage to ensure all important elements would be included in the research report. During the writing stage, linkages were made to identify patterns within and between codes. Information in the reflexive memo was considered at this stage. Discourse analysis, especially on the obligations of stakeholders, included consideration of the textual information, the discursive practices and the social cultural practices that results from such discourse. This involved the triangulation of data sources, including interviews and document analysis.

CONCLUSION OF METHODOLOGY

Through the use of case study methodology, the research strived to uncover the multiple complexity of the policy issue of migration of nurses to Canada through the Live-in Caregiver Program by considering contextual influences and also using multiple sources of evidence. A single holistic typical case study design was used; the unit of analysis was nurses from the Philippines who migrate to Ontario through the Live-in Caregiver Program. First, pertinent documents were analyzed; second, interviews with live-in caregivers were conducted; and third, stakeholders were interviewed. The researcher paid close attention to issues of quality including reflexivity, positionality, and ethics, by implementing such measures as the use of reflexive

memos, the use of multiple data sources, and the use of Parrenas' and Hochschild's theoretical propositions.

**CHAPTER 5: “WHY ARE YOU INTERESTED IN US”: REFLEXIVE ENGAGEMENT
IN THE FIELD**

My positionality as a researcher was frequently challenged during the data collection process as participants often asked the question: “Why are you interested in us?” Although this question may seem as simple as: why are you interested in the topic, the context and tone of the question pointed to the participants' need for an answer to the question: “Whose side are you on?” and “Are you going to help us?” As a Black African immigrant and a Registered Nurse in Canada, this question about “us” and “them” often pushed me to a critical reflexive stance with respect to my research and my relationship with prospective participants. The question challenged me to continuously, critically reflect on my motivation, the purpose of the study, and the goal of my research.

When I began the doctoral program, my initial interest was to explore the experiences of internationally educated nurses who failed to complete the process of registration in Ontario. During a pilot study earlier in my doctoral program, I interviewed six internationally educated nurses, including one (Olivia) who migrated to Canada through the Live-in Caregiver Program. This interview exposed me to the experience of live-in caregivers in Canada. Around this time, I was reading the work of Gayatri Spivak (1988) titled “Can the Subaltern Speak?” Relating it to my work, I considered the question: “Who are the subalterns in nursing?” Considering the power and voice of nurses who migrate to Canada through the Live-in Caregiver Program, my answer was that this group of nurses is the group most likely to fit with Spivak’s (1988) ideas on subalterns.

The power and voices of women from marginalized societies has been the focus of Gayatri Spivak’s work. In her major work, she asks the question “Can the subaltern speak?”

(Spivak, 1988). Spivak (2005) described subalternity as a “position without identity” (p.478), “where the social lines of mobility ... do not permit the formation of a recognizable basis of action” (p. 476). It is difficult for the subaltern to make their class interest count because of their subjugated position or standing in the society. The goal, according to Spivak, is to bring the subaltern from a state of crisis to the logic of agency. This strategy is contrary to dominant notions that since the subalterns have no history and no voice they must be spoken for and be represented. The intellectual must continually question and examine his or her positionality as well as challenge hegemonic notions of voice (Spivak, 1989).

With this view, it is important to consider individuals and groups in society who are so severely marginalized that they may be considered the subaltern. Beginning with Gayatri Spivak’s ideas, my goal was to create channels of agency by ensuring this group of nurse’s stories and voices are represented in the nursing academic literature. At the time of conceptualizing this study, there existed no literature in a nursing journal focused on internationally educated nurses working as domestic workers in their destination country (despite evidence that this trend exists). However, this study is not only limited to hegemonic powers which are perpetuated through colonialism and neocolonialism. Using the concept of global care chains, the study also explores how these processes are shaped by policy systems, taking into consideration the global political economy, feminism, class, and race. Also, within this discourse, I consider the agency of nurses who migrate to Canada through the Live-in Caregiver Program by exploring how they challenge and negotiate their dislocations.

Due to the demographic profile of individuals in the Live-in Caregiver Program, most of my research participants were from the Philippines (while I am a Black African Canadian). This racial profile creates some similarities (as a Black African women, I am also a minority race in

Canada) and also differences (I am not from the Philippines). Several third wave feminist writers (including Gayatri Spivak, 2005, and Chandra Talpade Mohanty, 1991) have argued against an essentialist notion of women and third world women. Chandra Talpade Mohanty (1991) argues against the production of the “Third World Woman” as a single monolithic subject in her essay “Under Western Eyes: Feminist Scholarship and Colonial Discourse”. Such a homogeneous view of women in non-western countries conceives of women as being an ahistorical primitive “Other”. In this dissertation, I adopt the views of Mohanty (1991), Spivak (2005) and Parrenas (2001) on third world women, which necessitate a reflexive stance, taking into consideration during the research process and analysis, my biologic positioning, including points of connections and disconnects.

In an effort to be cognizant of how my biographic history affects the research process and data analysis process (Alvesson & Skoldberg, 2000) while conducting this research, it was important that I locate myself as a participant throughout the research. This process leads me to question my prior assumptions and the multiple subjectivities that I employ. Using a reflexive lens to ensure that marginalized voices are heard is as important as starting where the research participants start and taking the story from their standpoint. The intent was to understand the experience subjectively and reflexively, to see how this experience intertwines with “regimes of power” (Foucault, 1982).

Another nuance of the question (why are you interested in us?) is the preference for a Filipina to be the researcher for the study. This preference for a Filipina to represent the views of Filipina’s was often passed in subtle ways. Another underlying message was, considering the various challenges of African and Black Canadians, why are you interested in Filipinas and not in Africans or Blacks? This later sentiment was not only expressed by Filipinas, but also by

Africans and other Canadians who learned the purpose of my study. Consideration of these ideas led me to further examine my positioning in relation to the participants.

As a non-Filipina, I tried to gain an insider's view of their experiences, by taking keen interest not only in the issue of nurses who migrate to Canada through the Live-in Caregiver Program but also in the experience of Filipinas in Canada. In examining my positionality, I continually considered my location in my interaction with the participants. Being seen as an outsider versus an insider or vice-versa determined the way the research was structured and the kinds of information informants provided. At the same time, I showed respect for the research informants while taking into account the power relations that exist. Since informants have multiple realities, I acknowledged these multiple realities by paying attention to stories from some live-in caregivers that may have seemed divergent from the majority of live-in caregivers.

Despite my location as a non-Filipina immigrant, several members of the Filipina community were very supportive of the study and sometimes invited me to events within the community. Moreover, the shared identity of 'immigrant' was often passed through various channels, as some individuals who communicated with me over the course of the study ended their emails to me with the phrase "in solidarity". The solidarity message was to identify the collective interest as an individual advancing the cause of working class Filipinas in Canada. Solidarity also signifies a collective working class struggle towards liberation.

My identity as an immigrant and acculturation was sometimes questioned during the research process. For example, one representative of a recruitment agency for live-in caregivers asked during a preliminary telephone discussion if I was in Canada during Ruby Dhalla's trial¹².

¹² Rubby Dhalla was a Member of Parliament in Canada who, in 2009, was accused of abusing and exploiting live-in caregivers who provided care to her mother.

Hearing my voice (and non-Canadian accent), this was a strategy to learn how long I had been in Canada and my level of Canadian acculturation. While the preliminary discussion was to evaluate her eligibility to participate in the study, she was evaluating what kind of information she was willing to provide to me; my identity as an immigrant may have structured the type of information she provided or how she provided such information.

I also perceived social positioning from being a researcher and Registered Nurse in Canada while most of my participants were not registered to practice as nurses in Canada. During the interviews, I tried to bridge this gap by paying particular attention to the research atmosphere, including the sitting position and allowing the stories to evolve from the participant's stance rather than on a strict set of questions or guidelines. This attempt, as well as my acknowledgement of the participants as internationally educated nurses, meant a more robust set of knowledge as well as a diminished presentation of the "researched self". Despite this, some participants (such as Josephine) asked at the interview's end whether they had provided me with "good" answers. However, my general purpose was not to get "good" answers, as the answers are situated within the historical, social, and cultural experiences of the individual and the knower.

Confronted with an outsider (the researcher) who is relatively unknown in the community, live-in caregivers tapped each other for support to share their stories while at the same time developing trust with the researcher. Conversely, as a researcher, I was cautious about asking for certain kinds of information early in the interview as I wasn't sure how participants would react to such questions. By the middle of the interview, I was able to ask demanding questions related to polarized views both within and outside the community.

In conclusion, the positions of the researcher and research participants played a key role in the research process, including how individuals felt at various times and how the study was conducted. In an attempt to ensure the rigor of the study, I maintained a reflexive stance throughout the research process. As an immigrant woman myself, I found these women's stories of professional sacrifice to gain a better life and Canadian citizenship for their family poignant.

CHAPTER 6: RESULTS 1: “ALL FOR THE FAMILY”: MIGRATION TO CANADA

INTRODUCTION

The typical migration pattern followed by live-in caregivers interviewed for this study involved migrating from the Philippines to the Middle East (most commonly Saudi Arabia), and then to Canada. For these nurses, the initial motivation to emigrate was driven by poor economic conditions in the Philippines. The subsequent motivation for migration to Canada to work as a live-in caregiver was to achieve Canadian citizenship for the family. This chapter answers two research questions: 1) Why do Philippine educated nurses migrate to Ontario through the Live-in Caregiver Program? 2) What are the expectations of Philippine educated nurses who migrate to Ontario through the Live-in Caregiver Program? After presenting the migration story of one of the participants, Kristine, this chapter discusses, first, the reasons or motivations for nurse migration to Canada through this immigration route, including economic status, and social drivers; second, the reasons for choosing to migrate as live-in caregivers as opposed to skilled workers; and third, the process of migration to Canada, including the role of individual support networks and live-in caregiver recruiters. Finally, the chapter focuses on the second research question, i.e. the pre-migration expectations of this group of nurses.

KRISTINE'S STORY

After earning her Bachelor's of Science in Nursing in the Philippines, Kristine worked in a military hospital in Saudi Arabia for fifteen years. In 2005, her husband and daughter moved back to the Philippines so that her daughter could be educated in a country where the language of instruction was English. While in Saudi Arabia, Kristine visited her family in the Philippines every six months. Kristine learned about the Live-in Caregiver Program from friends who had

left Saudi Arabia to work in Canada under the program. At first, she was hesitant to apply because of some of her friends' negative experiences. Eventually, Kristine chose to migrate to Canada by this route because she believed her family could gain permanent resident status in Canada. There was no immigration pathway to citizenship for her and her family in Saudi Arabia, and she was not allowed to stay in Saudi Arabia if she was not working. On applying for her first job in Canada, Kristine was turned down by the prospective employer. The employer thought she was over qualified. Kristine was a nursing supervisor in Saudi Arabia, while the employer's live-in caregiver position was for someone to take care of children. Kristine's friends later introduced her to a Filipino nursing recruitment agency to which she paid \$3,000 to migrate to Canada. Through this agency, she was able to get a job taking care of an elderly man with Alzheimer's disease. Although her family knew she was migrating to Canada, she did not let her family know that she said she would be working as a live-in caregiver until after she arrived in Canada. Looking back, she would have preferred to come to Canada as a skilled worker. However, she said she did not know about this choice of immigration route prior to arrival. Kristine felt the recruiter lied to her as she did not tell her about the option of the skilled worker immigration route, but gave her the impression that the process of becoming a permanent resident post-migration as a live-in caregiver would take a maximum of two years.

Kristine's story depicts a typical migration process that starts in the Philippines, proceeds to the Middle East (especially Saudi Arabia), and then to Ontario, Canada. It also shows some of the processes and motivations for migrating to Canada through the Live-in Caregiver Program, including the role of informal networks in the migration process and the goal of citizenship.

MOTIVATIONS FOR MIGRATION

This section provides insight into the motivations for the migration of nurses to Canada through the Live-in Caregiver Program. As will be shown, the quest for higher economic status motivates nurses to emigrate from the Philippines. However, on arriving in the Middle East (especially Saudi Arabia), the quest for citizenship and a more favourable lifestyle for themselves and their family motivates them to migrate from the Middle East to Canada. After describing their economic, lifestyle, and citizenship motivations, the reasons why these nurses chose the Live-in Caregiver Program over the Skilled Worker Program will be described.

Economic Motivation for Emigrating from the Philippines: “Because my mom told me”

All participants completed a four-year baccalaureate degree in the Philippines after ten years of elementary and secondary school education in the country. Their main motivation for emigration was to ease the financial strain experienced in the Philippines and the difficulty of finding employment. Some participants stated that while they might have been able to survive economically as a single person in the Philippines, it was very difficult for a family to survive on a local salary without receiving remittances. Realizing this, parents often encouraged their young children to go into nursing. A nursing education eases the ability to go abroad, to earn a higher salary, and to be able to support family members through remittances. Helen discussed how she was encouraged by her mother to enter nursing:

Interviewer: *Why did you become a nurse?*

Helen: *Why, because my mom told me, she wants me to become a nurse, so she enrolled me in college.*

Interviewer: *Why does she want you to become a nurse?*

***Helen:** Because she thinks nurses have a lot of money. Because it is easy to go abroad.*

Once individuals become trained as nurses, it is often difficult to find a job in the Philippines. Participants reported that nurses in the Philippines often have to volunteer (without pay) as nurses in the Philippines in order to find a job (either in the Philippines or internationally). The financial burden is further compounded by the requirement to pay a fee in some hospitals in order to volunteer. Even after finding a job, the compensation nurses receive is often too little to support a family. This was the case for Grace. In order to make up for the low pay, Grace worked two jobs, as a company nurse and as an operating room nurse. This left her with very little time to see her children and she relied on her mother's help to raise her children.

Filipina nurses can find it particularly challenging to find jobs in the nursing profession, even after the completion of voluntary hours of service. After trying to find work for a while in the Philippines without success, nurses may change professions. This tendency is further compounded by the challenge of finding good paying jobs. For instance, Josephine had to accept an "office job":

*I graduated nursing, I went to work. My salary is basic.... When I went to the hospital there, the salary they are offering is just equivalent to a sales clerk salary. So I, I cannot live, it's not enough. So, I opted to go to an office job which has a higher pay. **Josephine***

The issue of low salary is particularly problematic for nurses who work in more rural areas. Josephine noted that hospitals in urban areas (where the pay is often higher) preferred to hire nurses who graduated from well-recognized universities located in a metropolitan area. Thus, Josephine experienced the added challenge of finding a nursing job because she graduated from a university in a more rural area. Even though she knew she was losing valuable skills by not working as a nurse, Josephine preferred to work in another occupation as she felt the pay of a

nurse in the Philippines is much lower than the responsibility that the position warrants.

Josephine reported that one reason for the low pay is that hospital managers know that nurses often work in the hospital only to gain the one to two years' experience that is needed to work abroad. Due to this, hospitals either pay nurses very low wages for the first two years or require nurses to volunteer without pay, for which they may even charge a fee.

Michelle also changed her profession. She became a teacher when she was unable to find a job as a nurse. When she graduated from nursing school in the 1990s, Canada was not recruiting internationally educated nurses due to an over-supply of nurses. There was also very little demand for nurses in the United States. As a teacher, she found a job at the school where her mother was an administrator. However, she felt both her and her husband's income were insufficient to provide for their children. On realizing that job opportunities were available in Canada to work as a live-in caregiver, she volunteered in a Philippine hospital for one year while working as a teacher. This was her gateway to getting a job in Saudi Arabia, with the final goal of getting a job in Canada as a live-in caregiver. Describing Saudi Arabia as a "stepping stone" to being able to migrate to Canada, she worked in Saudi Arabia for nine months before migrating to Canada to work as a live-in caregiver.

Economic and Social Class as a Motivation: Migration from the Philippines to the Middle East to Canada

After completing and passing the exam required to migrate to Saudi Arabia, this Philippine educated nurses used the services of the Philippine Overseas Employment Agency, or the help of private recruitment agencies. While working in Saudi Arabia, the nurses interviewed for this study enjoyed higher pay (and the ability to send remittances to the Philippines), two

months of vacation per year, and free housing, as well as higher social status (as compared to nurses who were working in the Philippines) and the ability to work in their profession.

Michelle was the only participant who articulated a clear strategic plan to go to Saudi Arabia as a “stepping stone” (i.e., part of the plan) to migrate to Canada through the Live-in Caregiver Program. However, the other participants interviewed also noted that working temporarily in Saudi Arabia was a good mechanism for going abroad because it was much easier to go there than to other countries. According to the participants, Saudi Arabia was a good “stepping stone” to working as a nurse in the United States, Canada, and the United Kingdom, rather than to working as a live-in caregiver or domestic worker.

All the participants who migrated from Saudi Arabia, except Michelle, made their decision to migrate to Canada as a live-in caregiver while they were working in Saudi Arabia. Interestingly, none of the live-in caregivers interviewed identified financial gain as influencing their choice to migrate from Saudi Arabia to Canada. While some stated they earned more money as a nurse in Saudi Arabia than as a live-in caregiver in Canada, others stated that the pay was the same. Individuals who recently migrated to Canada were more likely to cite a higher rate of pay in Saudi Arabia as compared to Canada:

I work in Saudi Arabia, I work in the hospital. I am earning bigger money than here....

*Yes, and then there is no tax, tax free. And then I go for vacation, it's free also. So, every ten months we can go home, and its free, the ticket for our plane. **Bridget***

For Bridget and the other nurses interviewed, there were also other financial benefits of working in Saudi Arabia, such as a free plane ticket home to the Philippines each year. Furthermore, Philippine educated nurses in Saudi Arabia enjoyed free housing and transportation, which

resulted in their ability to save more money and send a higher remittance home to the Philippines.

While economic gain was a driver for the migration of nurses from the Philippines to Saudi Arabia, participants alluded to the role of social status as influential in their decision to migrate from Saudi Arabia to Canada. Several nurses stated that even though in the Philippines being a domestic worker (such as a live-in caregiver) is seen as being very low, “like a servant” (Kristine), the opportunity of working in the United States, Canada, or the United Kingdom balances the low status. Nurses who live in these three countries are seen as having a higher social status in the Philippines than individuals who live in Saudi Arabia, regardless of the work that is being done in the destination country:

Because, you know, Canada is like US. So the US is almost the same like Canada....

*When you hear it's from Canada, it is a little bit better than Saudi Arabia, especially in the Philippines. In our country, if you hear that you came from Saudi, it's just a common thing to hear. But if you came from the US or Canada or England, it's more higher economic status. So, the first thing I think of coming to Canada, I am not thinking of what are the life I will face when I come to this country. **Amy***

Their belief at the time of migration was that they would have a luxurious lifestyle in Canada. Helen also noted that individuals who live in Canada are perceived in the Philippines to have a higher social status than individuals who live in Saudi Arabia:

*But, my mom was saying 'you go there', because it is different when you are in the Philippines or in Saudi Arabia. Once you came here in Canada and the US, you are big time already. **Helen***

As a result of living in Canada, Helen was able to improve the financial status of her parents who were in the Philippines. She was able to buy them a nice big house. Similarly, Francesca noted that on migrating to Canada, due to her “higher income position” and the higher standard of living of her family members in the Philippines, many in the Philippines had a perception that life was much better. Francisca who was working as a live-in caregiver at the time of the interview, had a lot of servants in the Philippines, even though her children were grown:

*Being a caregiver is the lowest position really in the Philippines. There we can pay a lot of servants ... [because of] a higher income position that we have. So you can pay [for] ten servants if you want.... My children are actually big, but still they need a servant, like what we're doing here. See we are working as caregivers, but we have caregivers [laughs]. You can hire as many servants as you want. **Francisca***

Participants who migrated from the Philippines to the Middle East enjoyed a higher economic and social status in the Philippines due to the higher income they earned in the destination countries. However, they noted that even though they were able to work as nurses in Saudi Arabia and were working as live-in caregivers in Canada, in the Philippines there is a perception that working in Canada is equivalent to having a higher social status than working in Saudi Arabia. As illustrated above, there is a perceptual difference in class mobility between Saudi Arabia and Canada. While these nurses migrated from the Philippines to Saudi Arabia primarily for financial benefits, improvement in lifestyle and social status influenced their decision to emigrate from Saudi Arabia to Canada.

Lifestyle as Motivation: Migrating from the Middle East to Canada

One reason commonly cited by participants for emigrating from Saudi Arabia to Canada was to have a better life for their children. In Saudi Arabia, there are no opportunities for families to stay permanently unless a member of the family is working as a migrant worker in the country. Some participants said that Saudi Arabian schools are not good for children. For instance, when it was time for Kristine's child to enter elementary school, she sent the child back to the Philippines. According to Kristine, the quality of education was not as good for Filipino children and they were taught Arabic and the Islamic way of life, which she did not want her child to learn. Although there are international schools in Saudi Arabia where her children could be taught in English, they were too expensive. Grace summarized the trade-off as one of choosing a better way of life for her children, particularly in relation to religious freedom, in the statement below:

*And then I heard that some of my friends are applying (and) coming here to Canada. And then I thought my reason for going out again, working abroad, is ... just to use Saudi Arabia ... just a way to go to an open country where I can bring my family. Because Saudi Arabia is not that open. I can bring my children there if my husband is there, we can stay there, but eventually I will send them back because I don't want them to grow [up] there. **Grace***

By "open country", Grace means both the ability to become citizens and also have religious freedom for herself and her family. Francisca also spoke about issues of religious freedom. While Francisca stated her religious practice decreased while she lived in Saudi Arabia, Grace commented that in her experience, the atmosphere sparked a level of spiritual "longing", that is, a desire to become more spiritual.

Amy, Bridget and Catherine also pointed to the lack of a pension plan in Saudi Arabia and that as one gets older, one begins to consider long-term plans for retirement and one's children's future. Moreover, all three nurses believed that younger nurses were preferred by employers in Saudi Arabia. They commented that officials in Saudi Arabia do not like to hire nurses above the age of 35. According to participants, the work for nurses in Saudi Arabia was for "young nurses", those who can do more work. However, older nurses need to start thinking about alternatives, especially for a better retirement plan and a better life for their family after they can no longer work as nurses.

These issues of retirement plans and age were stressed by Irene who was 55 at the time of the interview:

It's so-o hard [in the Middle East] when you are getting older. Like here in Canada, even you are old, when you are 50 to 55, it doesn't matter. There is no age limit here, that's why I love [being] in Canada. Irene

At the time of the interview, Irene was having difficulties with sponsoring her daughter, who had a developmental disability. During the interview, she contemplated going back to work in the Middle East. However, since she was in her mid-50s, she was aware of the stark differences she would experience in the Middle East versus Canada due to her age. Knowing that life is better in Canada as a retired immigrant, she decided to remain in Canada rather than migrate back to Saudi Arabia.

Canadian Citizenship as a Motivation: "All for the Family"

For all participants, the main appeal of the Live-in Caregiver Program was to have a better life for the family. "All for the Family" was the most common phrase participants used

when describing their reasons for migrating to Canada to work as a live-in caregiver. Despite the fact that working as a nurse in Saudi Arabia was much better financially due to the excellent benefits, such as two months a year vacation, in the end individuals who choose to stay in Saudi Arabia are unable to gain full citizenship. By migrating to Canada, participants sacrificed their short-term goals by working as live-in caregivers while living away from their family, but gained in the long-term because they eventually qualify to become citizens and bring their family to Canada.

Despite the benefits of working in Saudi Arabia in a professional occupation, participants chose Canada where they could gain full citizenship. Grace described the sacrifice of working as a live-in caregiver to achieve the long-term goal of gaining full citizenship for her family in Canada:

And that is my main purpose in coming here. I thought, I can start, even in the lowest position, as long as in the long run ... I am looking for the future, that I can bring my family and we can all be together. Its all for my family, that's my purpose in coming here.

Grace

“All for the family” implies making individual sacrifices by working as a live-in caregiver to gain citizenship for the family. Participants were motivated to migrate so that their family, including their husband and children could become Canadian citizens and earn all of its associated rights.

Although neither Bridget nor Helen had a husband or children, they too agreed that the main appeal of the Live-in Caregiver Program was the opportunity to bring one's family to Canada. Bridget often regrets coming to Canada as a live-in caregiver because of the minimal benefits she has gained since she had no children:

*But, I mean, as a single [person], you have these regrets because you are telling. ... At least they have family, they have kids and it's their purpose why they came here in order for their kids to grow up here, to be educated here, and to have a brighter future. But for me, I will not be able to bring my family here. ... At the back of my mind, I'm thinking what's the real purpose? Why did I come here? **Bridget***

Bridget's comment represents a negative case as she had no children and no plans to sponsor any member of her family. Her questions and doubts about the decision reinforce the idea that gaining citizenship for the family is the strongest reason for the migration of Philippine educated nurses to Canada through the Live-in Caregiver Program (especially from the Middle East). For these participants, the strongest pull to Canada was the ability to achieve citizenship for their families.

REASONS FOR NOT MIGRATING TO CANADA AS A SKILLED WORKER

While participants commented on the appeal of citizenship and their social motivations for migrating to Canada through the Live-in Caregiver Program, it is important to note that some respondents might have qualified to migrate to Canada as skilled workers, a more favourable migration pathway as there are no limitations on citizenship status and no requirement to work as a live-in caregiver. In contrast to live-in caregivers, individuals who migrate as skilled workers can take advantage of a range of government support services, including educational programs and financial support. Four of the participants claimed to have been unaware of the skilled worker immigration pathway and now state they would have preferred to migrate through this route. For instance, Kristine stated:

So I don't have any idea of coming here as skilled worker. When I came here, some of the people told me, why you did not come here as immigrant I didn't know about it. When I came here I realized [this and thought] why I did not come here as an immigrant?

Kristine

Kristine felt that the recruiter misled her as she had all the necessary requirements, including financing, to be able to migrate to Canada as a skilled worker. Similarly, Bridget stated she was unaware that she could have applied as a skilled worker and only realized this after she arrived in Canada:

*I have a classmate here, when she realized I came here, we had a communication through Facebook and she told me, 'Bridget, why did you come as a live-in caregiver, why did you not apply as an immigrant?' I told her, I don't have any idea really. Just my friend told me to apply. I just tried and that's it. I really didn't have any idea that they are open for immigrants. **Bridget***

The Citizenship and Immigration Canada website posts information both on the Skilled Worker Program and the Live-in Caregiver Program. However, Kristine and Bridget stated they were unaware of the skilled worker immigration route. Six of the nurses who migrated through the Live-in Caregiver Program lacked some of the requirements necessary to come to Canada as skilled workers. This was the case for Josephine and Michelle who had less than one year of experience as nurses in the Philippines. Another four participants could not have afforded the cost of skilled worker migration. In order to migrate to Canada as a skilled worker, internationally educated nurses must demonstrate that they have sufficient income to survive in Canada; this amounts to more than \$11,000, in addition to the cost of airfare, a significant cost (CIC, 2013e). Compared to the Federal Skilled Worker Program, the Live-in Caregiver Program

represents a lower cost option for these workers as they do not need to provide proof of funds as migrant workers. Moreover, on December 2009, Citizenship and Immigration Canada (2009a) announced a new requirement necessitating employers to pay for all immigration and travel cost for live-in caregivers. Employers of live-in caregivers must pay for:

- travel costs for live-in caregivers to come to Canada;
- medical insurance until live-in caregivers become eligible for provincial health coverage; and
- workplace safety insurance and any recruiting fees owed to third parties.

While only one participant had migrated to Canada after this announcement, future nurses who plan to move to Canada through the Live-in Caregiver Program will have even lower costs associated with this immigration route as compared to the skilled worker route. Overall, nurses chose the migration path based on their knowledge of the options available as well as their nursing experience and economic resources pre-arrival in Canada.

In addition, some nurses chose the Live-in Caregiver Program because of the time it takes to migrate as a skilled worker:

Because when I checked on the Internet, it is really hard. You know, there is lots of step by step process. And then, there is no guarantee that I can come immediately.... One of my friends in Saudi Arabia when I was there, she told me about coming here directly as a nurse, but you have to pass the English exam and you have to show money to come over here. Amy

While Amy mentioned the language exam, this was not identified as a barrier by the other participants. But several participants commented on the length of time it takes to migrate as a skilled worker and the lack of guarantee that they would be approved to come as other barriers to

migration by this route. For instance, Federal Skilled Worker Program applications applied for in the Philippines before February 27, 2008, took 70 months to complete, indicating that those who applied through the program in January 2008 were still awaiting application review when these interviews were taking place in 2012 (CIC, 2011c). Both Helen and Olivia identified length of time for migration as a skilled worker as an issue when asked the reasons for choosing to migrate as a live-in caregiver rather than as a skilled worker:

Because it is a long process. It will take how many years and lot of money to spend. And ... you don't have any assurance that you will come here. Helen

I also regret like I'm getting here, like I was in a hurry. I thought I want to get in here in three months' time. That's why I took the Live-in Caregiver Program... instead of applying for immigrant status, which will take five years [or] above. Olivia

Given the general experience of nurses who migrate as live-in caregivers, the three participants who were currently working as nurses expressed the view that if they were in the same position that they were in when they migrated to Canada, they would still migrate to Canada through the Live-in Caregiver Program. The responses from twelve individuals who had not started practising as nurses were mixed on this point. In general, the participants (especially those from Saudi Arabia) were part of a close network that kept each other up to date on immigration options. This illustrates the link in the global care chain and the role that networks play in facilitating global migration.

SOURCES OF MIGRATION INFORMATION

Getting Information from Networks

Informal support networks played a key role in the migration of study participants to Canada through the Live-in Caregiver Program. Although these Philippine educated nurses expressed a preference to migrate to Canada, the United Kingdom, or the United States, they often moved to Saudi Arabia first as it was easier. Once in Saudi Arabia, they met other nurses who were in the process of migrating to Canada through the Live-in Caregiver Program. Seeing that their friends were successful in relocating to Canada, these Philippine educated nurses in Saudi Arabia became motivated to migrate to Canada to work as live-in caregivers:

First of all, I learned about the Live-in Caregiver Program from my friend. We were in Saudi Arabia and then she told me that it is good to come here to prepare for the future of our family. Amy

The live-in caregivers in this study also discussed how their friends who were already working in these roles in Canada provided information to them on their experience, specifically regarding the unskilled labour they performed in their employers' home. For instance, when Grace came to Canada, she told Catherine, who was still living in Saudi Arabia, about her experience as a live-in caregiver:

I don't want to discourage her [Catherine] So I told her, if you cannot work as a servant, don't come here, stay there. You are already okay there with your position, eight hours of work, good salary, and you have your sixteen hours all by yourself. So I told her, don't come here. Otherwise, if you have a very strong and good motivation to come, stay and sacrifice, starting [from] zero, then come here. Then she finally decided okay, I will.

Maybe she thought: 'if I can do it, she can do it too'. That's also always my mentality. If they can do it, maybe I can do it better. **Grace**

Even though they received cautionary information from their friends, the participants thought about the prospect of having better lives in Canada and accepted work as live-in caregivers. They compared themselves to their friends who were already working in Canada and thought that if their friends could work as live-in caregivers, then they should be able to do the same.

Differences in the information sources used depended on their immigration pathway. All but one of the participants who migrated directly from the Middle East (n=10) noted they received information from friends, while all those who migrated directly from the Philippines (n=3) had family members in Canada who provided them with information.¹³ Prior to their migration to Canada, Irene, Josephine, and Leah relied on family members in Canada for help with the recruitment process. Irene came to Canada mainly to help take care of her sister's children.

The Role of Recruitment Agencies

Recruitment agencies were another source of information for nurses who migrated to Canada through the Live-in Caregiver Program and they played a pivotal role in the migration and settlement of this group in this country. Representatives of a recruitment agency group interviewed for this study noted that family members and friends were the main sources of referral. One recruiter and recruitment group representative summed this up, stating:

¹³ In addition to those who migrated directly from the Middle East and the Philippines, one live-in caregiver migrated from Germany and another from Taiwan.

You know, and of course agencies know, people have friends, family members might call a recruitment agency and say: I have relatives over there, can you help them? So there's different means. But I think I would say these are the three main ones. Recruiter 1

The main sources of referral were family members, friends, and prospective live-in caregivers themselves. Recruiters noted a high demand from individuals wanting to migrate to Canada as live-in caregivers. As one recruiter stated:

My God, we get so many emails from people who want to come and work in Canada in the Live-in Caregiver Program. Recruiter 1

The recruitment of live-in caregivers to Canada is a burgeoning business, both in the Philippines and in Canada. There are several training programs in the Philippines to prepare individuals to work as live-in caregivers in Canada. According to Citizenship and Immigration Canada (2013f), in order to migrate to Canada, live-in caregivers must have “at least six months” of training or at least one year of full-time paid work experience as a caregiver or in a related field or occupation (within six months with one employer) in the past three years’. Nurses who migrate to Canada through the Live-in Caregiver Program often meet this requirement and are not required to complete a live-in caregiver training course. Only one participant had completed a live-in caregiver training program in the Philippines and this was because she had limited experience as a nurse.

Recruiters like to hire nurses because of their skills. However, there are limited resources to assist in the eventual nursing workforce integration of these skilled immigrants. This is because the focus of the Live-in Caregiver Program is to obtain immediate post-migration employment rather than support the final career goal of becoming a nurse. This priority was echoed by an immigration policy participant who confirmed that Citizenship and Immigration

Canada has no specific policies related to nurses who have applied to work as live-in caregivers in Canada, rather than as nurses.

Study participants felt they had received insufficient information about the migration and nursing registration process from recruiters. Recruiters tended to provide little information on the nursing registration process, the type of work that would be done in the home, or the length of time to complete the Live-in Caregiver Program. According to study participants, recruiters charged between \$3,000 and \$5,000 for information and assistance with the migration process. In fact, recruiters have a business, wholly commercially driven model with a primary emphasis on maximizing profit. Recruiter 2 and Nurse Educator 4 reported that live-in caregivers often borrow money, sometimes from an affiliate of the recruiter group, in order to migrate to Canada. Hence, live-in caregivers may become virtually indentured to the recruiter to whom they must (indirectly) repay the money borrowed.

In December 2009, the Government of Canada passed a law to prevent recruiters from charging live-in caregiver recruitment fees. The current policy of the Live-in Caregiver Program requires employers to pay any recruitment fees, airfare, and medical insurance. Nevertheless, participants believe that some recruiters still charge live-in caregivers to migrate to Canada. The sole participant who had migrated to Canada after December 2009 had paid recruitment fees in order to migrate. Given this policy change, recruiters have refocused their business strategy by creating advertisement sites, funded by employers. For instance, the website www.canadiannanny.ca charges \$44.99 for activation and \$6.99 per month for employers to access live-in caregiver applicants.

On arrival in Canada, live-in caregivers may be “released on arrival”, a well-known phrase to both caregivers and recruiters. This implies that a caregiver arrives in Canada to a job

that actually does not exist. In these cases, on arrival in Canada, the live-in caregiver must look for an employer in order to continue to stay in the country. Recruiter 2 stated:

And then the caregivers get released upon arrival to find their own job. But they've come [with] terrible debt and some of them didn't know they were coming to a fake job. Some of them do. A lot of family members that were sponsoring their family or had other people sponsor their family members knew that the job was fake, but they were willing to have them come, just to get them into the country. But it was wrong. **Recruiter 2**

As Recruiter 2 states, being released on arrival is particularly common among caregivers who have been exploited by taking loans from affiliates of recruitment agencies to migrate to Canada. Family members may encourage their relatives in the Philippines to come to Canada, even when there are no jobs available for them. Hence, in the process of trying to help a prospective migrant, family members may become active participants in the eventual exploitation of the caregiver. Nannette spoke about the challenges she faced after she was released on arrival:

It's bad ... with the recruiter. I paid \$4,500 US dollars just to come here. And knowing now the regulation of the government, knowing the inside-out of Live-in Caregiver Program, you don't need to pay any cents. And because of my being naive at that time, I don't know my rights. I don't know what's going on with the government. All I know is to work and earn money. And I was released upon arrival. I think that's very common for caregivers. **Nannette**

On arriving at the Toronto airport, Nannette had no job, and had to call employers the next day to see if she could find a job. Her lack of proficiency in the English language made the process of talking to potential employers particularly difficult. Despite this challenge, she arrived in Canada

on Wednesday and was able to find a job by Sunday. Similarly, Danielle noted that by the time she arrived in Canada, her employer no longer needed her:

*When I came here, there was a family that sponsored me when I was in Saudi. But apparently, when I was here that family, they don't need me anymore because I wasn't able to come on the certain month they wanted me to come. **Danielle***

Hence, Danielle had no employer on arrival in Canada. Nannette, who now co-chairs a live-in caregiver support group, described how the Philippine government has tightened regulations to prevent this form of exploitation, especially after a policy was implemented by the Canadian government in December 2009 requiring employers to pay all recruitment fees. However, she also pointed out that individuals migrating from outside the Philippines (e.g., those migrating from Saudi Arabia) may still be susceptible to this form of exploitation as they do not go through the Philippine Overseas Employment Agency.

While some participants had negative experiences with recruiters, others commented on the beneficial role recruiters played in assisting in their socialization to Canada. Helen said that the greatest benefit she received by working with her recruiter is that the recruiter introduced her to Catherine and Grace, who were able to mentor her in adjusting to Canada as well as in her nursing career:

***Interviewer:** What do you think your recruiter can do to help you more?*

Helen:** [LAUGHS AND LOOKS AT CATHERINE] My agent, hmmm. Up to now we have communication so I think she gave me the right person, this [LAUGHS AND POINTS AT CATHERINE]. So, yeah. **Helen

Although Helen's recruiter charged her recruitment fees, even after the policy shift that eliminated charging these fees to caregivers, she still appreciated that her recruiter was able to connect her with support groups and that she retains open communication with her.

PRE-MIGRATION EXPECTATIONS

All participants interviewed had expected that they would become a nurse in Canada after they completed the Live-in Caregiver Program and that they would become a permanent resident in Canada immediately afterwards. None were aware that the process to become a permanent resident and also to become a nurse in Canada actually takes approximately three to seven years after arrival. All but one participant (Josephine, the only one to have completed a live-in caregiver educational program in the Philippines) said they lacked sufficient information about the length of time it takes to complete the Live-in Caregiver Program. Other than Josephine, the participants expected to practise their profession after 24 months of arriving in Canada:

*I thought that [after] 24 months being a caregiver that I can apply. I was so disappointed And then I thought, I think I made the wrong decision coming here. **Grace***

This misunderstanding of the length of time required to become a nurse in Canada is reinforced by information provided by the Citizenship and Immigration Canada on its website which states the minimum time it takes to qualify or become eligible to become a permanent resident in Canada. For example, one Citizenship and Immigration Canada news release in December 2011 states:

“Caregivers are obliged to work for two years, or 3,900 hours, and then become eligible to apply for permanent residence in Canada.”

Live-in caregivers often incorrectly equate the amount of time it takes to become eligible to work in Canada with the amount of time it takes to become a permanent resident in Canada. Hence, they are unaware of the extended period of separation from family members they must endure. Furthermore, while information on the time it takes to become eligible for permanent residency is widely available online, information on how long it actually takes to become a permanent resident in Canada is not as accessible.

Despite the goal of becoming a nurse in Canada, to be successful in the migration process, contrary to a professional image of being a nurse, live-in caregiver advertisements often emphasized the ability to give of oneself. The advertisement below (from TLC Edmonton website) emphasizes this trend:

I'm Mrs. Marites Santos¹⁴, 44 years old. A College Graduate with a Bachelor of Science in Nursing I worked in Taiwan and am presently working in Saudi Arabia... The patient I worked with over the years have truly become a part of me.... I am ready and looking forward to learn a new daily routine that is tailored to my future employer.

With images such as the ability to learn a routine based on the needs of the future employer, the focus of most live-in caregivers is to satisfy employer's needs and expectations of a "good" caregiver, rather than their own needs, including professional aspirations. In doing this, live-in caregivers begin constructing themselves to potential employers as someone who can put aside their own emotional needs and provide a wide range of emotional labour while expecting nothing but financial payment from employers.

¹⁴ A pseudonym (fake name) is used.

SUMMARY AND CONCLUSION

In conclusion, the process of migration of nurses to Canada through the Live-in Caregiver Program begins before prospective nurses enter nursing schools in the Philippines. Individuals are motivated to enrol in nursing schools to increase their chances of being able to migrate out of the country, and subsequently be able to send remittances back to their families. On arrival in destination countries, such as Saudi Arabia, they achieve a higher financial status than in the Philippines but they lack citizenship rights. The eventual appeal of the Live-in Caregiver Program relates to the ability to become citizens in Canada as well as to gain Canadian citizenship for their families. However, despite the available information posted on the Citizenship and Immigration Canada website, some caregivers reported that they were unaware that another option existed, that they could achieve the same goal of Canadian citizenship by migrating to Canada as skilled workers. Others were aware that they could have migrated as skilled workers but chose to migrate through the Live-in Caregiver Program due to the multiple requirements of the skilled worker program, including significant financial cost, time, language requirements and years of experience. Therefore, prospective live-in caregivers make a largely pragmatic choice regarding their migration route.

Clearly, social networks (including family and friends) are an important element of the global care chain in the migration of nurses to Canada through the Live-in Caregiver Program. These live-in caregivers often obtained information about migration to Canada through family and friends, both in Canada and in their last place of residence, such as Saudi Arabia. Nurses who migrated to Canada through the Live-in Caregiver Program had the added expectation of being able to become a nurse in Canada. However, their information on how to fulfil these expectations (i.e., the time it takes to become permanent resident and the process of becoming a

nurse in Canada) was often deficient. For some, friends tried to provide a glimpse of the reality of working as a live-in caregiver. However, the prospective benefit of gaining citizenship for the family in Canada clouded the reality. As will be shown in the next chapter, the choice of immigration route increased this group of internationally educated nurses' susceptibility to exploitation and challenges to becoming a nurse in Canada.

CHAPTER 7: RESULTS 2: EXPERIENCE IN CANADA

INTRODUCTION

Rhacel Parrenas (2001) theorized that domestic workers experience partial citizenship, feelings of social exclusion and non-belonging, the pain of family separation, and contradictory class mobility. This chapter discusses how these dislocations were experienced by this group of nurses. The chapter answers the research question: Do nurses from the Philippines who migrate to Ontario through the Live-in Caregiver Program experience the dislocations of contradictory class mobility, partial citizenship, pain of family separation, and feelings of social exclusion and non-belonging? If so, how do they experience these dislocations, and how do they resist or negotiate these experiences?

Three of these dislocations were strongly expressed by study participants: contradictory class mobility, partial/non citizenship, and the pain of family separation. Feelings of social exclusion and non-belonging are intricately woven into their experience as non-citizens in Canada. Although Parrenas discussed employer-employee relationships under the experience of contradictory class mobility, employer-employee relationship issues emerged as a strong theme throughout the participants' experiences and deserve distinct attention. The first part of this chapter describes the participants' experiences with respect to their citizenship status and non-belonging. The second part of the chapter describes their experiences as they relate to the employer-employee relationship. The third section describes the pain of family separation, while the last part describes contradictions in class mobility. In each part, data are presented on how this group of nurses negotiate their experience in Ontario.

**PART A: “THERE IS A CHANCE THAT THEY WILL NOT ACCEPT ME”: THE
EXPERIENCE OF PARTIAL CITIZENSHIP AND NON-BELONGING**

Introduction

Gaining citizenship for the family was the predominant reason for the migration of this group of nurses to Canada. However, challenges exist in achieving this goal. As previously discussed, while some participants used the services of recruiters, others were sponsored by family members (n=3). On arrival in Canada, nurses who migrate through the Live-in Caregiver Program must work for a minimum of 22 months in this role, during which time they must have a work permit. Upon completion of the program requirements, they may apply for permanent resident status. The first stage of the application for permanent residency is to gain an open work permit in Canada. Once this step is accomplished, the application proceeds to approval for permanent residency for both themselves and their family. The next section of Part A examines the experience of live-in caregivers as non-citizens in Canada, beginning with their perception of seeking a work permit in Canada, followed by their experience seeking permanent resident status. The last section discusses how they negotiate or resist these experiences.

Seeking Work Permit

Before arriving in Canada, live-in caregivers are issued a work permit, specific to an employer. However, eight of the participants had to change employers, and therefore required a new work permit. These participants found it takes three to four months to get a work permit with a new employer in Canada. This period of waiting to receive a new work permit is not counted towards the 22 month requirement of the Live-in Caregiver Program. Due to pressure to complete the Live-in Caregiver Program within the allowed four years, these caregivers are

motivated to avoid losing their position as it has the potential to affect their ability to become a permanent resident in Canada.

A further problem arises for live-in caregivers when their employers did not pay employment insurance. Live-in caregivers (like Danielle, Kristine, and Michelle) were in this position and as a consequence were disadvantaged on their path to permanent resident status. The live-in caregiver is not officially employed unless the employer pays employment insurance and applicable taxes. Hence, the failure of employers to pay employment insurance as well as deduct and pay necessary taxes resulted in a delay for these three live-in caregivers to become permanent residents and to sponsor their families to Canada:

*So, I'm working with them like for 24 months. And then from the month of August 2009, they started to pay my tax. But prior to that, I was with them from the month of March 12, so I wasted like almost seven months.... I waited seven months for her to start to pay my tax. But for us, as a live-in caregiver, as soon as you are with that employer you need to push for them to pay your tax so that our months will be calculated. Otherwise nothing will happen for us. **Danielle***

The length of time it takes to change employers and get a new work permit often creates a challenge for live-in caregivers. Four of the participants reported being abused. Live-in caregivers who are abused may be reluctant to report or leave an abusive employer because they are concerned about the effect of changing employers on their ability to gain permanent resident status in Canada. Danielle described how consideration of the time it takes to gain a new work permit tied her to an abusive employer:

And then my friend will tell me, you gotta get out from there, look for another person to work with. But I cannot go for another person to work because another three months you

*are going to waste again. Because of the processing, you know. So I just keep on
Because of the papers, thinking about the papers. So I say its ok that they are doing this
[to] me, I'm just after the paper. After my paper will be finished, so maybe I just have to
go. **Danielle***

Despite advice from friends and support networks to leave, Danielle chose to stay with an abusive employer until she was able to complete the Live-in Caregiver Program.

Moreover, live-in caregivers may be put in the position where they sign an unfavourable contract with a new employer just to gain a work permit and complete 22 months to become a permanent resident in Canada:

*Like, if they interviewed you, you need to commit on what is in their agreement or else they will not hire you. So, whatever was their agreement, I accepted it because before them I already went to a lot of interviews and they didn't need me.... This second employer of mine, they said that this is what we need. Can you work like this? Like that? So, because they already needed me, so I agreed, and I need them also because the count of my 24 months is already going. It's already behind. **Michelle***

Seeking Permanent Resident Status in Canada

Even after completion of the program, live-in caregivers commonly need to wait for a significant length of time to become a permanent resident in Canada. The live-in caregivers interviewed for this study had been in Canada between three and seven years prior to gaining permanent resident status. Before migrating to Canada, they thought it would take 24 months:

But the only thing that is struggling me is the time of waiting. Just like now I'm happy that I submitted my paper but the waiting time again for 18 months to be able to be

*permanent resident. You know, when I think about it, Oh it's still 18 months, still long time.... Actually when I came here I thought it was two years only. Then I don't know that after two years that much long time I have to wait. **Kristine***

In December 2011, Citizenship and Immigration Canada announced that live-in caregivers will be granted open work permits immediately after the completion of the program requirements. The live-in caregivers interviewed for this study were happy with these changes but they expressed dissatisfaction that an open work permit does not equate to permanent resident status. This is because while individuals with an open work permit have more rights than those under the Live-in Caregiver Program, they still have fewer rights than those who are permanent residents in Canada. An open work permit enables live-in caregivers to work at any type of job in Canada. However, permanent residency status is required to be eligible for several social and income support programs, as well as post-secondary educational funding (such as the Ontario Student Assistance Plan), which could be helpful on their journey to becoming registered nurses in Canada. The process of seeking permanent resident status often creates an added stress, as one commented:

*We are not doing anything bad. We don't have any bad record. So, why not make it, you know. And then there is also a risk that we will not be approved for our application in some instances. I thought, I already spend time, money, effort with this. It's like, I am entitled to it. But still, there is a chance that they will not accept me¹⁵. You know, it's like I pay a lot for this. But still, you are not sure. So, I hope they can do something about that immigration. **Grace***

¹⁵ The underlined words were said in a low voice.

Grace described how some individuals migrate to Canada as refugees and are able to gain permanent resident status faster in Canada than live-in caregivers who have completed their work obligations. She was frustrated that she came to Canada through a legal route and considers she has provided important service to Canada, but has not been granted the right to citizenship. The “chance” that their permanent resident application could be denied caused anxiety and worry among the participants. Their pain was intensified by considering the sacrifices they had made as nurses who come to Canada to work as domestics.

Abusive employers (n=4)¹⁶ reminded live-in caregivers that they were not citizens and threatened them with deportation should they report an abusive relationship. For instance, Danielle’s employer, who was often abusive to her, told her that “you need to bite your tongue”. Danielle was very much aware of this threat to her status:

*If you need to bite your tongue, you mean, whatever, maybe they will ask you to clean, to do this, to do that, I need to do, because of the papers. Otherwise, without them, without her, my application will not be processed. **Danielle***

Danielle’s employer also used legal tactics to challenge and prevent her from gaining citizenship in Canada. First, she told the police that Danielle and the client (the employer’s father) were engaging in sexual relations, claiming that the client was touching Danielle in a sexual way while Danielle was assisting him with mobility. When the police came to the home, they interviewed Danielle but took no further action. Then the employer accused Danielle of manipulating the client’s pills:

¹⁶ All the participants were exploited (to varying degrees) as live-in caregivers in that none of them received appropriate overtime pay. While four participants had abusive employers, another three had negative, although not overtly abusive, experiences with their employers. Eight participants described their relationship with their employers as “good”. This section is limited to discussing their experience of becoming citizens. The next section describes their employer-employee relationships.

'You are switching those pills, which is illegal'. She is telling me like that. So really, she is making all those story, like a mess; she is really trying to put me down.... Because she knows that I'm leaving, she is making me a problem; she is making a trouble for me, you know. Danielle

The employer attempted to get Danielle into legal trouble and prevent her from gaining citizenship in Canada because she knew that Danielle would be leaving the family soon. Helen also felt threatened with deportation. When she told her employer that she was considering leaving due to her abusive attitude, the employer responded that she should “go back to the Philippines”.

Negotiating Non-Citizenship: Creating Support Systems

In this study, nurses who migrated through the Live-in Caregiver Program negotiated their non-citizenship status through various means, in some instances, by joining support and advocacy groups. Support groups allowed them to learn about their rights in Canada, while creating a network of support to challenge employers and also to challenge the system, including immigration policy. A range of support groups was used by these live-in caregivers, including online groups.

Several Facebook support groups have been developed to advocate for live-in caregivers rights in Canada. For instance, one Facebook support group – Strike Nannies – was created by live-in caregivers, on the open discussion forum www.canadavisa.com, an online discussion group, after discussion about their frustration over the time it takes to gain permanent residence status in Canada. As the name implies, the goal is for nannies to organize a strike to challenge immigration policymakers on the length of time it takes to become permanent residents after the

completion of the Live-in Caregiver Program. Live-in caregivers created a petition site in mid-2011, shortly after which, in December 2011, the government announced the granting of open work permits to more than 10,000 live-in caregivers. In the announcement, the Minister of Citizenship and Immigration Canada commented on the role that advocacy efforts within the Filipino community played in shaping immigration policy:

I want to honour the advocates in the caregiver community, the Filipino community, and other organizations who have given a voice to the voiceless, who have stood up for those who really don't have any political power in Canada, those who really don't have much economic sway, but who have been a strong united voice. That is the reason that I am standing here today. **Honourable Jason Kenney, Citizenship and Immigration Canada, 2011**

Analysis of documents (including online petition sites) and interviews with support group representatives revealed that the use of advocacy groups helps to increase the political power that live-in caregivers have in Canada and counteract their status as non-citizens in Canada.

Advocacy groups within the Filipino community are often headed by former live-in caregivers with the support of members of the Filipino community. The advocacy group representatives interviewed described how they disseminated information through both informal networks and formal information sessions (such as workshops on live-in caregiver rights in Canada). Live-in caregivers also receive help from online discussion forums (such as canadavisa.com) where they can ask questions about the migration process as well as seek support from fellow caregivers.

Negotiating Non-Citizenship: Use of Weekend Homes

Without family in Canada, live-in caregivers draw on support from one another and from within the Philippine community to re-create a familial bond. One strategy to re-create their own space and community while being legally required to live in their employer's home is through the creation of weekend homes. While live-in caregivers are required by immigration policy to live in their client's home, they comply with the policy by living in the client's home five days a week but then spend the other two days in a weekend home. The weekend home is often an apartment used by live-in caregivers on the weekend to "escape" staying at their employers' homes. Interviews were conducted in three weekend homes during the course of this study, all of which were owned by previous live-in caregivers. In what the participants reported to be common practice among live-in caregivers, the lease of these weekend homes were passed along successive 'generations' of Filipina caregivers to create their own space and belonging.

The three weekend homes visited were one-bedroom apartments, shared by five to seven live-in caregivers who paid a small fee (around \$100 a month) to stay in the home on weekends. All apartments visited had two couches covered with a sheet of cloth so that the live-in caregivers can sleep on it on the weekend. While the weekend homes were one bedroom apartments, the couches provided extra space to allow five to seven live-in caregivers to sleep on the weekend. Also present in the home was (at least) one Bible to further inspire their spiritual life. In one weekend home where I conducted an interview on a weekend, I observed their positive relationships as they cooked together, created pseudo-familial bonds, and exchanged ideas.

Having a second (i.e., weekend) home protected the emotional health of this group of nurses. Kristine commented on the benefits of weekend homes to her emotional well-being:

I tried my best to cope with whatever it is; because Monday to Friday, I work, and Saturday and Sunday I go out. Saturday and Sunday I took off and I come to an apartment. I already look for an apartment where I can stay for Saturday and Sunday because, I said, oh my god, if I will not go out for two days I will be crazy.... But we are happy [staying in a weekend apartment] because at least we are out from the employer.

Kristine

Amy elaborated on the break the weekend home provided from the isolation she experienced by living in the employer's home. The weekend home provided an informal atmosphere of socialization for live-in caregivers, where they cooked together, went to church together, and shared and discussed their similar experiences and issues. Indeed, during my interviews with live-in caregivers, I observed how they drew on each other's support to challenge and negotiate their non-citizenship status and their experience of non-belonging in Canada.

Conclusion

In conclusion, on migrating to Canada, live-in caregivers must maintain a work permit to complete the program's requirement. Participants indicated the process of getting a new work permit to work for a new employer took approximately three months. Considering the long processing time, live-in caregivers may decide not to leave an abusive employer since that will likely delay them in reaching their goal of permanent residence. In addition, caregivers may agree to sign a work contract they realize is unfavourable so that they can complete the 24 month live-in caregiver requirement. Participants in this study reported that employers were aware of

the role they play in ensuring the live-in caregiver becomes a permanent resident in Canada, and they may use this to control the employee, reminding them of their dependence and vulnerability. This power differential that arises from the non-citizenship status of these caregivers in their initial years in Canada places them at risk of being exploited.

Live-in caregivers have created advocacy and support groups with the help of former live-in caregivers to challenge the limits to their rights and freedoms and leverage their political power in Canada. By living with other live-in caregivers in a weekend home, they are better able to learn about their rights in Canada as well as create pseudo-familial bonds and a sense of belonging. This is particularly important considering the negative experiences they may have in their employers' home. Living and working in the same location, without family members in Canada, accentuates their experience of isolation. Thus, weekend homes help in challenging and alleviating the dislocation of partial citizenship in Canada. Next, employer-employee relationships will be explored.

**PART B: EMPLOYER AND EMPLOYEE RELATIONSHIP: “I AM SLAVE AND THEY
ARE MASTER”**

Introduction

Parrenas (2001) did not identify the employer-employee relationship as a major source of dislocation experienced by domestic workers on arrival in their destination country. However, this theme emerged strongly for these caregivers. Part B describes the relationship between employers and caregivers, beginning with positive relationships between employers and live-in caregivers, then positive relationship between live-in caregivers and care recipients, and finally negative employer-employee relationships. The third section focuses on the familial versus employment bond between live-in caregivers and employers. The last section examines how live-in caregivers negotiate and challenge the relationship between themselves and their employers.

Positive Employer-Employee Relationship

Participants expressed both positive and negative aspects of working in the home of the employer. Eight¹⁷ participants spoke of having a “good” relationship with one or more of their employers. The description of a “good” employer often referred to one who kept to the parameters of the contract, paid for over-time hours, respected the live-in caregiver, and provided opportunities for career advancement. Josephine gave a clear description of a “good” employer-employee relationship:

¹⁷ Despite some live-in caregivers’ reports of good employer-employee relationships, most live-in caregivers were not paid for all hours worked and none were paid for overtime hours at 1.5 of times the regular pay rate.

*For me, what is a good employer?... Perhaps you also have to consider who is a good employee. A good employee have to know what is the employer's expectations. So, you have to put all your cards: this is my expectation, this is what I expect you to do and this is what I am able to give to you. In return, the employee knows what are my limitations and what are my responsibility. It is something basic. Because if an employee is expecting too much from the employer and the employer cannot give it to them or cannot understand what she wants, then she might say it a bad employer because it is not part of the deal. For me, a good employer is that they respect their employees. So if you respect your employees, you listen to them. **Josephine***

Josephine's description of the "good" employer recognized the reciprocity in the relationship and emphasized mutual expectations. Often when live-in caregivers describe expectations, they mean expectations that are stated in the contract, especially related to hours of work and pay. However, from Josephine's description, expectations also extend to the daily negotiation of the employer-employee role. She later explained that both sides must know "what are the employer rights and what are the caregiver rights" in order to meet expectations of the relationship and also in order to have a "good" relationship. The employer must also adhere to "basic human rights". Meeting these rights means that employers and employees must be able to act, that is, be "assertive", to ensure they are able to negotiate fairly within the relationship. While this study did not interview employers, Josephine's statement indicates the importance of considering the rights of employers and exploring perspectives of the employer-employee relationship from the employer's perspective. Josephine indicated that it is possible to have a "bad" employer; it is also possible to have a "bad" employee if expectations (especially as stated in the contract) are not met on both sides.

Live-in caregivers also identified “good” employers as those who are supportive of their career goal. For instance, Michelle had an employer who was able to provide her with a job working in the employer’s restaurant after Michelle received an open work permit. To ensure a smooth transition, Michelle was able to help the employer by training the live-in caregiver hired to replace Michelle in the home. Similarly, Emily had an employer who allowed her to work in her personal support worker school as an instructor while she was completing the Live-in Caregiver Program. Due to the “good” relationship she had with the employer, she helped the employer in hiring and training the next live-in caregiver hired by the employer. Emily described how she was able to gain valuable work experience while working with an adult client with a developmental disability who was enrolled in a day program:

*So while I was working with them, they bring me to the day program with their son and I start to work with the teachers in the day program. I involved myself. We cook, we go to picnics, like all the disabled. Because the person that I’m taking care of is with their day programs, so I joined and we stayed there for a day while they’re in their school. Mine is different. It’s more like they brought me out of the shell, they asked me to teach in their school. **Emily***

In both of these two cases, it is important to note the reciprocal benefits. Michelle’s case provides the most legal options for both parties: Michelle benefited by having the opportunity to work outside the home with a higher income while the employer benefited by being able to retain a “good” employee and continuity of service. Emily benefited as she gained valuable work experience on her path to become a nurse in Canada. Her employer also benefited by filling an area that requires much skill without having to pay a Registered Nurse in Canada to work as a

personal support worker instructor. As Emily noted, she was not paid for this additional service, but really appreciated the experience she gained.

Having a good employer also helped live-in caregivers to have “good” job satisfaction. For instance, Josephine, who had a good relationship with her employer, noted:

*I also have job satisfaction in what I do. **Josephine***

Also, Grace described how she had a “good” employer, and was able to save money because she was living in the employer’s home. By living with the employer, she was able to learn about the Canadian way of life before her family arrived in Canada:

*It’s good to be in the Live-in caregiver Program because being new in Canada and being with one family is like you are in a comfort zone.... So, if you are there, you have your accommodation there, although we are paying also. You have your food there, and you are still inside the comfort zone... adjusting to the place, everything Canadian way of life. Then I can see, oh, this is how it is when my family are here. It’s like, I have a pattern, I have the idea [of] how it is. So, it helps, in some ways, many ways. **Grace***

Positive Relationship with Recipient of Care

Live-in caregivers often enjoyed providing direct care to their clients. They spoke of their dedication to the children, the elderly and the disabled clients they cared for in the home. Live-in caregivers who cared for children described how they treat these children like they would their own children in the Philippines. Even live-in caregivers who indicated they had a “bad”¹⁸ employer often treated their clients like their own family members:

¹⁸ Negative employer-employee relationships will be described later.

*I'm really having a hard time staying with that family because I don't have any problem with the patient I'm looking after. Even though no matter how hard, you know, [it is] to take care of him ... because I'm lifting him up, exerting my energy, all my effort, because I was treating him like my father. **Danielle***

Participants often described how they treated their elderly clients like their own parents and how they treated the children as they would their own children. As Emily described, they extend the “tender loving care” they learned as part of their nursing education in the Philippines towards the individuals they provide care for in the home. This extension of “love” and dedication to the individuals they care for often ties live-in caregivers to unfavourable working conditions, as Helen described:

*On my first month, I want to search for another employer but I love the children sooo, it is soo hard for me to go. **Helen***

Despite feeling abused and exploited, emotional bonds between the live-in caregiver and the recipient of care tied the live-in caregiver to the unfavourable working relationship with the employer.

Negative Employer-Employee Relationship and Conflict: “Tragic Trauma”

While live-in caregivers like the direct care services they provided to children, the elderly, and the disabled, they spoke about how some employers abused and exploited them. Four live-in caregivers were abused by their employers; three spoke about having a negative relationship with their employers; while eight described having a positive relationship with their employer. The most common negative experience by live-in caregivers relates to employers not paying them for all hours worked. All the participants reported not being paid appropriate wages

for overtime hours worked. Employers often failed to follow the contract. Several live-in caregivers described working twelve to sixteen hours a day, but only getting paid for eight hours.

For instance, Olivia described her experience with not being paid for the hours she worked:

And then you have to pay like \$9 or \$10 per hour, but it's not also followed. So, it's like, you're giving the contract in immigration, and then you signed it. [Then you realize], like, "Oh my God! It's wrongful. They are not giving me the proper wage." **Olivia**

Even live-in caregivers who described their experience with their employers as positive noted a common pattern of employers not paying them for all the hours worked. Grace and Bridget, who stated that they had positive relationship with their employer, both identified being paid for fewer hours than worked:

Disadvantage for me being in the Live-in Caregiver Program: so like we are working there, supposed to be eight hours, sometimes we are extending [i.e. working more hours], but its ok. You know, even though it is a disadvantage, you work for them.... So, most of us are working extended time, but not additional payment. **Grace**

Realizing that their overall circumstances were better than those of their colleagues working as live-in caregivers, they did not challenge their employers to ensure they received full payment.

Four of the participants, Danielle, Helen, Leah, and Olivia, described the most negative experience, that is, abuse. Danielle talked about how she was exploited and abused by her employer when her employer failed to pay applicable taxes and employment insurance for the first seven months of her employment which meant she could not count the hours worked towards her permanent resident status requirement. Her employer often shouted at her and called her a liar. Even though she was working fourteen to sixteen hours a day, she was only paid for eight hours. Furthermore, though her contract stated she was to work in only one home, caring

for an elderly man, she was often asked to work in the home of her employer (i.e. client's daughter), doing gardening, cleaning, and laundry. The employer and the client's home were within close proximity to one another, on the same street.¹⁹ Below is her statement on working in the homes of her client and her employer:

The mother [wife of the client], when I came from outside, she tells me – ‘ok, I clean already the house, so 2 o’clock you go to the house of my daughter and you clean the house of my daughter’. First, I say ok. And then when I was cleaning in there, she will tell me ‘ok when the phone will ring you answer that one because that is the time my husband will want to go to the washroom.’ **Danielle**

The most traumatic experience for her was on a cold night in February when the employer called the police (as earlier described). Later that night, the employer accused her of wrongfully administering medications to her elderly client. After shouting at her, she was told to leave the client's house at 12:30 a.m. on a cold February night, leaving her homeless. During the interview, Danielle cried (Emily, who was present at the interview, also cried) as she described the trauma she experienced. She felt she was suffering from “tragic trauma” which she believed arose from living with her employer.

Helen experienced “depression” and “anxiety” in her employer's home. Her employer who was experiencing depression related to her divorce often shouted at her. Moreover, she expressed cultural conflicts, most specifically with food. As she was required to live with the employer and the employer deducted the cost of room and board from her salary, she was constrained in the type of foods she could eat:

¹⁹ The employer is the one who hires the live-in caregiver and pays the necessary fees. The client is the recipient of care, often children and the elderly. In cases where an elderly is the recipient of care, the employer is often the children of the elderly. In cases where children are the recipient of care, parents are often the employer.

I love to eat rice [LAUGHS] but here they love to eat fries.... I love rice so it's difficult for me to adjust. **Helen**

While some live-in caregivers were able to cook their own meals, some caregivers, like Helen, had to eat the same food as their employer. Another stressful cultural experience for participants was that of language barriers with families, especially with elderly immigrant clients. For instance, Kristine had a client who could only speak Italian. She found this very stressful as it interfered with the client-caregiver relationship.

The fact that these caregivers must live in their client's home creates a need for the development of a trusting relationship. In the home, the live-in caregiver is often the only one who is not a member of the family. Some live-in caregivers interviewed described that when something was missing in the home, the first suspicion was that it was stolen by the live-in caregiver. This was the case for Francisca, whose employer had put his wedding ring in an unsafe location on a Saturday. On Sunday night, Francisca arrived back in the home. On Monday, the employer discovered that the ring was lost:

I experienced from them one time that the wedding ring was lost. And so its weekend, I was not there and when I went back Monday, that ring was lost and then the husband told me that 'oh, it was just here for Saturday, Sunday, now its Monday, its not there'.

Francisca

Francisca thought that although the employer avoided directly accusing her of stealing the ring, there was an indirect accusation as the employer indicated the ring was lost after she came back into the home. The ring was eventually found. However, experiences such as this remind live-in caregivers of their vulnerability to accusations of stealing in their employers' home.

“One of the Family”: Familial Versus Employer-Employee Relationship

The study participants expressed clearly divergent views based on their experiences and their desire for a good relationship with employers. Some of the participants felt that they were treated as part of the family. For instance, Grace stated that her employer treated her like family, which she appreciates:

*My employers, they are really good. They treat me as part of their family. Even outside that family itself, the grandparents, the aunties, the uncles of the children, they are treating me really good, like I was part of the family. Like the children [are told] ‘Whatever she said, she is just like your aunty. When we are not here, she is just like your mummy.’ Yeah, like that. They are really good. **Grace***

When her employer directed the children to consider Grace like a family member, Grace felt respected and appreciated being treated as part of the family. Kristine also expressed a preference to be treated like part of the family. While working in the home of her first employer, Kristine felt she was treated like she was part of the family and often invited to family events. For instance, during the funeral of the client she was providing care for, she felt privileged to stand with the family to receive condolences and she was introduced by her employer as being a member of the family. However, with her second employer, she described being treated as a “slave”, expected to serve meals to the client and not allowed to eat while the client was eating. She described her experience as: “*I am slave and they are master,*” and the painful consequences of such a relationship:

*I mean you are in the same home. If they treat you as [a] slave, it’s not only torturing you emotionally, it’s torturing you as a person, as an individual, and it’s hurting. It’s very degrading on our part, you know. **Kristine***

The experience of being treated like a “slave” reminds live-in caregivers of the differences between the work they are qualified to do (nursing) and the work they are currently doing (domestic work). Moreover, this sort of treatment is interpreted through the cultural lens of the Philippines where being a “servant” is a degrading notion.

While Grace and Kristine preferred to be treated like part of the family, Danielle felt that employers use the idea of being “one of the family” to further exploit live-in caregivers. She would have preferred to be treated as an employee to minimize the scope for abuse:

*Yeah, she said we treated you like one of the family. I don't know how come she is telling like more than a family, when in fact, I was like a slave. The mother wants me to do the gardening. The mother wants me to do the ironing of the clothes of the daughter. They know very well that it's different from my contract. If they have the family gathering, I will be there with the father in the hotel which they rented until 12 midnight to 2 o'clock. She is not paying me for that, so where is the family treatment there. And then when the father also was rushed in the hospital, we bring the father like [at] 12 midnight, we stayed there for 12 noon as well. ... And then after my pay, I don't see any pay for that period of hours when I was staying in the hospital, so where is the family treatment there. You know what, I would like to be treated like an employee so that the hours, you know, that was stated in the contract will be followed, but it wasn't. **Danielle***

By emphasizing that Danielle was part of the family, the employer found ways to exploit her by requiring over and beyond what was in the contract. Moreover, being “part of the family”, exposed Danielle to expectations for unpaid work. Hence, while Danielle enjoyed the privilege of being a family member, she lost financially by not getting paid for her extra labour, since she was “one of the family”.

Josephine presented clear insight on this issue. She felt she did not mind being treated as either an employee or family; the real issue related to respect. For instance, she used the example of how an invitation to a children's birthday party as part of being a family could be either a positive or negative experience for a live-in caregiver:

“What am I going to do there? Am I going to be served or am I going to serve?”

Josephine

When invited to birthday parties as a fictive member of the family, Josephine always questioned her role: is it to provide labour (by serving) or to enjoy the moment (by being served)? Her preference for being treated as an employee or as part of the family was based on the perceptions on both sides (i.e., employer/employee) of what it means to be an employee and a family member. Moreover, she emphasized the importance of having a clear boundary in order to prevent the relationship from being exploitative or abusive. From the comments among the participants, it was apparent that their response depended on the level of respect employers showed live-in caregivers and the evaluation by caregivers on the intent of their employer when stating they were part of the family.

Negotiating the Employer-Employee Relationship

Due to unequal relations within the home and their status of non-citizens, live-in caregivers often felt they could not challenge their employer when they were being abused or exploited. Helen described how she responded to her abusive employer:

It's hard for me... my anxiety increase when I saw them. I don't know what to do... So I use my silence mode. **Helen**

Live-in caregivers often responded to employers with silence (by not challenging the employer). Danielle responded to her abusive employer by “crying”. Most of the participants thought that the best way to deal with employers is to be assertive. For instance, Helen described how her employer often shouted at her. This disclosure stimulated a discussion between Helen and Catherine on how she should respond:

Helen: *I don't know if I will finish the 24 months with her. I don't know or maybe. This week she shouted at me again. Then, after 10 minutes, she said, 'sorry, sorry, sorry'. She is depressed, but sometimes I understand her feelings, but my anxiety increase when I saw her. That's why I don't know.*

Catherine: *Answer back. She should answer back in a nice way. She should tell in a nice way not to shout.*

Helen: *She always shouting, I don't know. Or sometimes she got home and I make the mistake and she shout already. But now, this week she shout at me twice. So I don't know maybe next month I ... [TAKES A DEEP BREATH]*

Catherine: *You cannot, she will always keep on shouting at you. It's not good.*

During the interview, Catherine (who was introduced to Helen by the recruiter to act as a mentor) encouraged Helen to be assertive and to leave her employer if she continued to be verbally abusive. Similarly, Amy (who had a “good” employer) stated that to be successful as a live-in caregiver, “you have to be assertive”. When asked what she would advise potential live-in caregivers so that they have a good experience in Canada, Danielle, too, emphasized the need to be assertive, and to ensure the employer complies with what is stated in the contract:

Of course, I need to tell them that at first, you should learn how to say no, what was on the contract, you need to stand by it....Of course, if you are working for the elderly or

disabled, you need to do what was on your job, you need to look after him. But after, what was really on the contract, if it's eight hours, you need to say, I'm finished, I'm done. Danielle

Assertiveness on the job is important to survive negative employer-employee relationships. As previously described, live-in caregivers can gain skills in assertiveness through informal networks of friends and by joining support groups.

Some of the participants drew on religion and spirituality to cope with their contradictory dislocation in Canada. Although Danielle was abused by her employer and said she experienced “tragic trauma”, she refused the counselling services recommended after her interview. Instead, she said she preferred to rely on the church to meet her mental health needs. For Danielle, the church provided a venue for both the socialization and spiritual needs of live-in caregivers. Similarly, while Francisca was looking for her client’s lost ring, she relied on prayer in the hope that it would help to find the ring and also to maintain her calm while she felt the employer was accusing her.

Conclusion

By utilizing support groups, social networks and religion, live-in caregivers strived to cope with and challenge their negative experiences in the home. Inequality within the employer-employee relationship is reinforced by the spatial relations in the home. Living and working in their employer’s home increases the vulnerability of live-in caregivers to exploitation, as well as conflict with the employer. In managing such conflicts, caregivers either respond with the “silence mode” or draw support from formal and informal social networks (including advocacy groups) to challenge and negotiate their experiences. Their contingent citizenship status in

Canada, as well as the lack of family members in Canada, further reinforces their vulnerability. Adopting the “silence mode” can be understood as a form of emotional labour as described by Hochschild (1983), to cope with their contradictory status in Canada.

PART C: PAIN OF FAMILY SEPARATION

Emotional labourers travel from poor to rich countries. However much a migrant worker wants to migrate, she often experiences a sense of loss and loneliness as she feeds, bathes, and plays with her client's children while living half a world away from her own (Hochschild, 2013, p. 30).

Introduction

The Live-in Caregiver Program requires caregivers to migrate to Canada without their family members, including their husband and children. While family aspirations drive live-in caregivers to migrate to Canada, the process causes them to be separated from their family for three to seven years, the usual period it takes before family members can migrate to Canada and gain permanent resident status. Family separation results in the emotional pain of being separated from their children and their husband. These two issues related to family separation will be discussed in the next section, as well as how live-in caregivers negotiate and challenge this pain.

Pain Related to Separation from their Children

Live-in caregivers can provide for the financial needs of their family with the higher income they earn in Canada but they are constrained by distance with respect to the emotional support they can provide for their children back home in the Philippines. Due to this contradiction, the live-in caregivers in this study experienced mixed emotions:

So, when I came here as a Live-in Caregiver, it is [with] mixed emotion. It is really hard for me to stay away from my family, especially my kids. So, it was really a very hard adjustment for me and my kids. Amy

The pain of family separation is intense for live-in caregivers. During the interviews, the questions that inspired the strongest emotional response were those related to children. While

only one live-in caregiver cried when asked about her children, several, including Amy and Kristine, took a deep breath while describing the pain of being separated from their family. Danielle cried when speaking about the negative experience with her employer. However, even though she had described earlier in the interview several negative experiences, she did not cry until she was asked about her children:

Interviewer: *How was it being here and your kids and your family are back home. Were you able to talk to them as much as you wanted?*

Danielle: *Yeah, because I'm having this Internet. So, in the morning when I woke up as well as in the evening before I sleep.*

Interviewer: *Do you ever miss them?*

Danielle: *Yeah, so much [STARTS CRYING].*

Interviewer: *What do you do?*

Danielle: *[STARTS WEEPING]*

Live-in caregivers are most emotionally affected when they think about the sacrifice they make for their children while not being able to live with their children. All the participants who had migrated directly from Saudi Arabia had not been living with their children before migrating to Canada. However, while working in Saudi Arabia, they could go to the Philippines for two months every year to see their children. In Canada, they typically waited until after the completion of the Live-in Caregiver Program before they visited the Philippines, a period of two to four years. Even though the Live-in Caregiver Program policy allows them to visit the Philippines, they usually do not go to the Philippines until after they have an open work permit so that they do not lose any time or jeopardize their chance of becoming a permanent resident in Canada. This can mean a lengthy separation from children.

This lengthy separation creates emotional tensions between children and parents. For instance, on arrival in the Philippines, Nannette found it difficult to re-create a relationship with her children after the long period of separation:

*I came December 22, so they pick me up at the airport. The following day, they want to go back to their dad. It's hard, but I'm getting used to it. I have to be tough, and I don't want to be carried away by my emotion. I'd been away in the Philippines ... for more than three years prior to coming here. **Nannette***

At the time of the interview, Nannette still had a negative relationship with her children. The relationship was further strained by the fact that Nannette had worked in Germany and Taiwan for three years before migrating to Canada, without seeing her children. In Emily's case, the lengthy time she had been separated from her child meant that on arrival in Canada, her child preferred to stay with other family members (as she was more used to this living arrangement) rather than live with her mom.

Marital Separation

Participants reported that marital separation was very common among live-in caregivers due to the lengthy separation between live-in caregivers and their husbands:

*But in my case or most of the cases of another caregiver, it's always broken family. ... I can't say that most of them or all of them, but 80 percent of the husbands left in the Philippines will have [an] affair. **Nannette***

Marital infidelity may occur on the part of husbands of live-in caregivers in the Philippines as well as live-in caregivers in Canada. Loneliness fosters this experience of infidelity. Emily's marital relationship ended while she was working as a live-in caregiver. Nannette and Emily felt

a great deal of pain over their experience of marital infidelity, especially since they felt they had sacrificed for their husband. Marital separation is also related to a change in gender roles. While live-in caregivers took care of someone else's children in Canada, their husbands often took care of their children in the Philippines with the help of extended family members and nannies. The children were much more emotionally connected to the husbands and other caregivers in the Philippines who raise them.

Challenging Pain of Family Separation

Live-in caregivers coped with the pain of family separation through three major means: emotional displacement, creating family networks in Canada, and the use of technology. The participants spoke of how they treated the children and elderly they cared for like they would their own, directing their "love" to their charges.

That's one thing my employer was very thankful of me. Because I am treating their kids as my own. Sometimes, I am spoiling them. My male employer was telling me, 'Amy, why are you doing that?' Because they are kids, they are also like my son. And, I was thinking, when I am going for vacation next month, I will miss them a lot. Amy

Moreover, participants also commented on how they displaced the feelings they have towards their own children onto those they tend. If they learned that their own children were experiencing a problem in the Philippines, they often related this challenge to the children they took care of in Canada. This is exemplified by Amy's comment:

Especially when someone is bullying them at the park or the library, yeah, I was very protective of them. Especially when my elder boy that I am babysitting — he is a quiet boy. He is active, but he doesn't mingle a lot with some other kids. He just wanted to stay

on my side. But when he wanted to take chances, he could play to somebody, but he always telling me that somebody who is very mean to him or who is bully him. Then I compare him to my kids, because one time when I was chatting with him, somebody is bullying him. Then I say, 'why, you should fight back'. Then I was thinking of the person I am babysitting, 'why you should fight back too because he is mean to you'. Amy

In this way, participants tried to cope with the pain of family separation by displacing their love, feelings and thoughts, from their own child to another child (or elder) with the hope that someone else will do the same for their children (or parents) in the Philippines. While taking care of other people's children intensified their emotional labour, it also helped to blunt the pain of family separation, as Michelle described:

Working in the home as a live in caregiver, it's not bad, you are just like at home taking care of kids or I already consider them as my kids. I miss my kids but because I was with kids, I took care of the kids, so I am considering them as my own kids, so it's not really that hard. Michelle

Live-in caregivers also challenged the pain of family separation by creating pseudo-familial bonds in Canada with the other caregivers they live with on the weekend, in a weekend home. For instance, Helen, who was 23 years old at the time of the interview, commented on how Catherine acted like her "mother" in Canada. This relationship helped Helen to cope with the loneliness of living in Canada.

Another helpful resource was technology. Participants relied on Skype, Yahoo Messenger, and the telephone to connect with their families in the Philippines and to maintain familial relations.

My kids, they are good, they are in the Philippines. But always, you know, I was thankful [for] the Internet. I could see them every now and then. Yeah, media calling. I was thinking I was always chatting with them, but only during weekends.

In addition to sending remittances to the Philippines, the use of technology assisted these live-in caregivers to perform their roles (of providing emotional support to children) as parents across a great distance. This extension of the familial role was made possible with the higher income earned by living in Canada.

Conclusion

The length of time of separation of family members during the Live-in Caregiver Program created emotional strain for these live-in caregivers. This strain was further compounded by the trend in transnational mobility of these workers, including migration to other countries before coming to Canada. In the absence of family members in Canada, live-in caregivers transferred the love for their own child to the child in their care. While this was a way live-in caregivers challenged their experience in Canada, this tendency poignantly illustrates the extraction of love from the South to the North (Hochschild, 2004).

PART D: CONTRADICTIONS IN CLASS MOBILITY

Introduction

Of the fifteen participants interviewed, at the time of the interview, one was successful in becoming a Registered Nurse in Canada, two were successful in becoming Registered Practical Nurses in Canada, six were in the registration process, two had stopped the process, and four had not begun (see Appendix D). Part D of this chapter summarizes the nursing registration experience of Leah, the only participant interviewed who was successful in becoming a Registered Nurse in Canada. Next, the experience of deskilling as well as barriers and facilitators in the integration of this group of nurses are described.

Becoming a Nurse in Canada: Leah's Story

Leah arrived in Canada as a live-in caregiver in 2001 and began the process of registering to become a nurse in Canada. She had difficulty obtaining the necessary documents from institutions in the Philippines and Saudi Arabia, and the process of registration took two years. She prepared for the examination by taking a nursing assessment and review course. Completing the nursing registration process was costly and financially very difficult for her as she was earning \$1,200 a month and she was sponsoring her family at the time. Also, her employer was not supportive of her goal. However, she identified an employee of the College of Nurses of Ontario who was supportive and encouraging. She attended a presentation given by a Filipina nurse and this inspired her commitment and discipline to continue her journey to become a nurse in Canada. She studied every night from 8 p.m. to 10 p.m. and on weekends. She wrote and passed the Canadian Registered Nurse examination in 2004 and left her first employer. Her next employer paid her \$2,500 since she had passed the nursing exam. In 2005, she began her first

Registered Nurse position in a nursing home in rural Canada. At the nursing home, she received a one-week orientation. She was quickly overwhelmed by caring for 70 patients and she quit the job after three months. After this experience, she was able to get a job in a remote area of Ontario which she liked. In this job, she received an award for excellence in the provision of care as well as a great salary and benefit package. She looks forward to eventually retiring in Northern Ontario and is very happy with her migration pattern.

Downward Mobility and Deskilling

Leah's story represents the most successful outcome of all the participants interviewed since she was the only one to become a Registered Nurse in Canada. The internationally educated nurses interviewed for this study experienced downward occupational mobility while working as live-in caregivers. When they worked in the Middle East, Philippines, and Taiwan, they gained valuable skills working in diverse clinical practice settings, including in supervisory roles. Many of the internationally educated nurses interviewed for this study also had specialized training, including in public health, intensive care nursing, and neonatal intensive care nursing.

As domestic workers in Canada, certain tasks created a great deal of stress for these participants. Of all the housework done in the home, what created the greatest stress was having to clean the toilet. While some aspects of the live-in caregiver job, such as making the bed, helping the client with mobility, and attending to emotional needs, may be seen as within the realm of nursing work, cleaning the toilet is not. In a hospital, cleaning the toilet is the work of housekeepers, a role that participants considered similar to working as a "maid" or "servant". They often cried during their initial months while trying to accomplish the task of toilet-cleaning. Below are some of the nurses' descriptions of their experiences:

*And one day the toilet was blocked. I don't know how to do it and the wife said, 'you do it'. And I was really crying and I said, 'oh God, help me'. **Kristine***

*The first three months I was crying when I was cleaning the toilet bowl and then brushing it. **Bridget***

*Of course, for me, I know it's degrading, you finish like a college degree and then you are working in a house like you are a servant, you are cleaning the toilet. **Danielle***

As described, many nurses cried as they experienced this “degrading” aspect of domestic work. Many of the nurses compared their domestic/caregiver job to working as a “servant” or working as a “maid”. Grace compared her experience as a live-in caregiver to that of a servant:

*Because there [i.e., in Saudi Arabia], our cleaners in the hospital, we are calling them servant. Like servant it looks like it is. As if you are the lowest one, servant. **Grace***

The experience of being a “servant” is further intensified by the time separation from working as a nurse in Canada. Most of the women interviewed had been in Canada for three to seven years and were not yet permanent residents in Canada. This length of time away from clinical practice leads to their deskilling; as Irene described, your skills become “rusty”:

*Not every time you are exposed to medical problem right. The one you learned will be rotten, it is going to be rusty, isn't it? There are so many modern techniques now than compared to the last time you work. Thinking for seven years, you are not exposed to that? Imagine, imagine, even if you attend this seminars, still it is not sufficient, right? That's it. **Irene***

While working as live-in caregivers, the women feared losing valuable clinical skills (such as starting an intravenous line and inserting a nasogastric tube), while at times they used and gained valuable relational skills in the home through their daily interactions with clients, especially the elderly and those with medical issues. Amy described how she used her nursing knowledge, especially her knowledge of psychology, in her work as a live-in caregiver:

Of course, in Saudi, you have to deal with other kinds of personality, especially with the patients, but here when you deal with your employer's personality and your employer's character, it's a different thing too. Anyway, you can adjust, you are a professional, you studied personality. It's part of being a nurse. Amy

In addition to these soft skills, the participants also utilized other clinical nursing skills, including assessment and management of diabetes and hypertension:

Because he is taking medication I have to take the blood pressure every day and the blood sugar.... I have to inform the doctor in case I observe things.... You know, if his situation is becoming worse, I have to inform the doctor, so basically [it's] one-to-one nurse-patient interaction. Kristine

As domestic workers, the downward occupational mobility from being a professional to working as a “servant” created an intense emotional responses for some of the participants.

One way this group of nurses negotiated their downward mobility in Canada was to “swallow their pride”. This phrase was frequently used by the participants and coupled with the notion of being submissive to the role of being a live-in caregiver and minimizing their professional training as nurses. The women maintained hope and relied on their religion while working as live-in caregivers to negotiate their deskilling and contradictory class status in Canada. Francisca discussed how she overcame her revulsion over having to clean toilets:

*So at the beginning you will really cry. You really feel humiliated... you really cry and then when you're cleaning the toilet and everything, like, oh my God, what life is this? ... But I really thank God because you know there is God that is always with me, reminding me, revealing everything to me. '[Being a] servant is not bad', something like that he [God] reminded me. Being a servant is not bad. That's only part of developing you to become more Christian. **Francisca***

Her religious beliefs and spirituality assisted Francisca to overcome her distress over her contradictory class mobility, by focusing on a higher calling and hope for a better future. In doing this, she focused on being able to achieve a higher level of spirituality due to the trials she experienced while working as a live-in caregiver. While Francisca used religion and spirituality to overcome her downward mobility in Canada, Amy focused on her upward social mobility as perceived by individuals in the Philippines:

*And then another advantage is well, of course, the status in your country and your place that, 'oh, you are in Canada'. The people [at home], they think you are already rich now, you are higher. **Amy***

Consistently, the participants referred to the idea that they enjoyed a higher social positioning due to working in Canada, even as domestics. Once they were in Canada, individuals in the Philippines often saw them as being elevated in terms of their social status in the Philippines.

Live-in caregivers coped with, challenged, and negotiated their contradictory mobility by focusing on the hope for a better future for them and their family. Kristine described this issue of hope:

Yeah. It's funny and it's heartache. It's mixed emotions, it's [a] mixed experience itself.

*Yeah, it's not easy. It's not easy, really. But, you know, I go on because of the hope, because of the word hope. **Kristine***

The hope Kristine described above is the hope of eventually having a better life in Canada, especially the hope of finally working as a nurse in Canada. To accomplish this goal, internationally educated nurses must overcome the barriers of becoming a nurse in Canada while making full use of any assistance they find to achieve this professional goal.

Barriers and Facilitators to Becoming a Nurse in Ontario

All the participants shared the pre-migration goal of working as nurses in Canada. However, to achieve this goal, they must be able to overcome barriers in the registration process while capitalizing on facilitators. The barriers to nursing registration included a lack of support from their employer, difficulties in credential assessment and access to bridging programs, cost, and passing the language and registration exam.

Contradictory Employer Support

During the interviews, the participants described the “good” versus the “bad” employer. Good employers were often described as those who encourage their employees to become a nurse in Canada. Bridget, Emily, Josephine and Kristine’s employers were supportive of their plans to go back into the nursing profession, including providing encouragement and providing flexibility in their work schedule. Some employers provided more support than is required under the Live-in Caregiver Program. For instance, Emily’s employer gave her an opportunity to work as an instructor for a personal support worker school owned by the employer. While working in

the employer's private college as a personal support worker instructor, she would bring the employer's adult child with autism to the class while teaching. Through this experience, she was able to earn a Canadian personal support worker certificate at no financial cost. This achievement leveraged her ability to become a Registered Practical Nurse in Canada by providing her with valuable Canadian experience. In describing her experience, she stated her employer "brought me out of the shell" by providing her with unique opportunities. Summing it up, Danielle and Emily noted that employers have the most significant role in the integration of nurses who migrate to Canada through the Live-in Caregiver Program:

I think the number one factor also that can lead you into your success is the employer that you have. If the employer is trying to put you really down, it affects also your plans.

Danielle

Danielle and Leah described how their employers were not supportive of their goal of becoming a nurse in Canada. Employers can enforce a non-supportive atmosphere for career mobility by not being flexible with employer arrangements. For instance, even though Leah was able to get someone to cover her shift with her employer so that she could pursue her nursing career requirements, her employer often "scolded" her and verbalized dissatisfaction with this arrangement. Similarly, Danielle received a negative response when she told her employer she wanted to become a nurse. Once she communicated this goal to the employer, the employer became increasingly abusive:

*After she found out that I was assessed by the CNO to write the exam, so she was like something, having this kind of — how to say this one — jealousy. **Danielle***

Moreover, participants reported that even otherwise “good” employers sometimes experienced contradictions in wanting to help caregivers to become a nurse in Canada and at the same time wanting to retain a great live-in caregiver. This experience is supported by Amy:

My employer was really good. They were nice people to me... But the thing of thinking of leaving them is really painful for them. And then when I was talking about my assessment, about taking my courses in college, they always felt nervous that I would leave them sooner... But she is not selfish, she knew that I need to pursue my career. Actually one time, she made me a letter to the CNO to follow up those papers. Amy

Nurse Educator 4 also corroborated this ambivalence of employers:

For the employer of caregiver, what would they want them to put their time on. It may not be studying to leave the family to work as a nurse. Nurse Educator 4

Grace also stated that her second employer wanted to keep her. Both Amy and Grace explained how they had good employers, and their employers valued them as good employees. However, pursuing a nursing career signified an impending end to a “good” employer-employee relationship since the employee would no longer be working for the employer after she became a nurse. No participant signified an interest in continuing to work for the employer or in homecare (even as a nurse) after qualifying to work as a nurse in Canada; their goal was to work in a hospital as a nurse.

Credential Assessment

In order to complete the registration process, participants required their documents to be verified. The two major issues with credential assessment are getting documentation on previous work experience and assessment of education in the Philippines as being equivalent to that in

Canada. Participants consistently described how difficult it was to get documents from the Middle East. In some countries in the Middle East (such as Libya), there is no nursing registration council and one participant had to speak to top government officials to get a letter that confirmed her work experience and confirmed that there was no nursing regulatory body in the country:

No, there is no board of nursing in Libya. They have school of nursing, but not board of nursing. But whatever is handling them is the ministry of health because I work in a hospital under the ministry of health. So, I have to call the CNO and explain, 'how can I provide you with this letter because there is no board of nursing in Libya?' ... And I said, 'what do I need to do?' And I was told to get a letter from the minister of health that supports that they don't have a nursing council in Libya. So I have to call directly, the minister.... Yeah, so I have to call the ministry, the Minister, MOH in Bengazi where I work, and ask [for a written letter]. **Emily**

The participants felt that the College of Nurses of Ontario should know about the regulatory frameworks of all countries (including in the Middle East) and have this information, and should not require participants to have to get letters of confirmation that there is no nursing registration body in a particular country in order to become a nurse in Canada.

All of the participants who had worked in Saudi Arabia were concerned that they would not be able to get documents from that country. This is because after five years of not working in a particular institution that is owned by the Ministry of Health of Saudi Arabia, the officials in Saudi Arabia will not provide written evidence that the nurse worked there. This inability to procure documents affects the ability of nurses to complete the registration process, and if they do complete it, they may be relegated to the lower category of Registered Practical Nurse rather

than Registered Nurse. Grace, who had worked in Saudi Arabia for over ten years, including as a nursing supervisor, experienced this move to a lower nursing status due to difficulties in obtaining work experience documentation:

*Because Saudi, they don't want to give any information even though I work there. That is just what we want for the verification of employment, just for them to tell that, yes you work here for ten years in this area, from this period to this period... And until now, I started my assessment when 2009 or 2000, yeah, I think 2009, and they didn't complete it. That's why that keeps me... They cannot assess me as an RN, so I apply to be assessed as a RPN. At least as a RPN, they will consider me without that verification of employment. That is thirteen years gone. **Grace***

This relegation of nurses with experience in Saudi Arabia to a lower rank due to their inability to provide evidence of their experience is unfortunate given the advanced knowledge and skills this nurses gained when working in Saudi Arabia.

The participants also faced challenges in meeting the educational requirements of the College of Nurses of Ontario. They spoke about how in the Philippines, graduating from a college or a university is seen as being the same. They stated that in the Philippines, nurses who graduate from colleges and universities both complete a four-year education and receive a degree. But the College of Nurses of Ontario rated internationally educated nurses from the Philippines differently based on whether they graduated from a college or a university:

It's because, you know, the colleges in the Philippines and the university, I don't have any idea that the colleges and the universities are different here unlike in the Philippines. Yeah, you know, in the Philippines if you graduate in the colleges and the universities it is the same. We have the same curriculum.... But for me, it is really disappointing.

Because they think that if you graduated from college, it means it's much lower than if you graduated from the university. Amy

Applicants are also assessed differently based on their year of graduation. Two Philippine-born educators of internationally educated nurses corroborated that internationally educated nurses from the Philippines tend to be assessed as Registered Practical Nurses instead of Registered Nurses. The rationale provided by nurse educators is that the elementary and secondary school education in the Philippines is ten years as opposed to the twelve years in Canada. Nurse educators speculated that the assessment of Philippine nurses as practical nurses may be due to this difference in elementary and secondary level education:

I think one of the challenges with respect to Philippine education is because, until last year, we only had the equivalent of Grade 10 in post-secondary education.... There was no Grade 11 or 12. And my understanding is that because of this situation, there's that gap in our educational system which results in credentials of Filipino nurses being evaluated as generally equivalent to a diploma because of that two year gap. Nurse

Educator 3

Another explanation for the assessment of nursing education earned in the Philippines may be due to the generally poorer quality of nursing education programs, especially with the increasing proliferation of nursing schools, as earlier described. This difference in assessment process, which reflects differences in the quality of nursing education programs in the Philippines, is stressful for these nurses since they were unaware that they would be assessed differently based on the type of their post-secondary schooling before they migrated to Canada.

Access to Bridging Programs

Once live-in caregivers complete the assessment process, they often need to take extra courses to be able to register as a nurse in Canada. This is because new nurse registrants in Ontario must demonstrate five years of recent, safe nursing practice, and they must have permanent resident status to be able to become registered in Canada. With the time it takes to become a permanent resident and subsequently become a nurse in Canada, live-in caregivers often need to take bridging programs. Kristine confirmed this by stating:

I still have a problem because according to CNO assessment I should be in my safe practice period, that is five years out of hospital service. If you miss that five years gap, then you are not safe, you have to go back to take the bridging [course]. **Kristine**

Moreover, a recently proposed policy change for new nurse registrants in Ontario now requires the demonstration of three years of recent, safe nursing practice. Since it takes two to four years to complete the requirements of the Live-in Caregiver Program and three to seven years to become a permanent resident in Ontario, this means that almost all internationally educated nurses who migrate as live-in caregivers have been required to complete bridging programs since January 2013. The study participants, who were interviewed between February 2012 and October 2012, were not aware of this proposed change, even though it affects their future ability to practice in Ontario. However, the nurse educators were aware of this proposed change and identified potential issues that nurse/live-in caregivers would face:

CNO has changed [their criteria for demonstrating] safe practice. It was five years and it's now dropped to three. What would that do to the people that come in as caregivers? I

wonder about them. It's going to put [live-in caregivers] more in jeopardy. **Nurse**

Educator 4

Even though most nurse/live-in caregivers are required to take bridging programs, they experience difficulty in doing so because they often work twelve hours a day, five days a week. They are only available to attend bridging programs on the weekends, yet government-supported bridging programs are often only available during the week. Both Amy and Bridget experienced barriers in accessing bridging programs due to the schedule of such programs:

But the thing is my time. The thing is, you know I am a live-in caregiver, I'm still working as nanny, so, it's five days per week. The colleges, they didn't offer a lot of subjects during the weekend, so I need to take it during weekdays. So, the problem is, how can I take those things during weekdays when I have a job? **Amy**

So, I was also interested [in attending a bridging program] and we talk to [a representative of a bridging program] and she told us to immediately take the subject that we need to take. But the problem is they are offering the subject on weekdays and we are full-time working as a live-in caregiver.... It's hard for us because they were telling us to take the subject but there is [none available on] weekends. I mean, the only time we are available is during the weekend. **Bridget**

The participants also reported that they were not allowed to take educational courses of more than six months duration as it exceeded the time limit set by a policy of the Live-in Caregiver Program. This means that nurse/live-in caregivers must wait until they complete the Live-in Caregiver Program to be able to take bridging courses. This restriction in taking courses is consistent with the goal of the Temporary Foreign Worker Program, which is focused on

meeting labour market needs. However, the restriction constrains the career goals of these workers as potential permanent residents in Canada. With these barriers in taking upgrading and bridging courses, the participants reported difficulties in passing the nurse registration exams.

Cost

Barriers to completing nursing registration are compounded by financial concerns and also the mental health issues arising from conflict with employers. At a minimum, the costs related to registration in Ontario includes: \$678 for the application for credential evaluation as a Registered Nurse, \$542 to write the Canadian Registered Nurse Examination, \$40 to write the jurisprudence exam, \$231.65 for initial registration with the College of Nurses of Ontario, and \$300 for writing the English language examination (College of Nurses of Ontario, 2013d), for a minimum total of about \$1,800. Live-in caregivers stated that they earned between \$1,000 and \$1,300 per month, and the cost of bridging programs is also expensive. Educational service providers charged international student fees, an amount typically between \$11,000 and \$13,000, for those working as live-in caregivers or employed with an open work permits. This amount generally exceeds what a live-in caregiver earns in a year. This means that even though live-in caregivers can take bridging courses while on open work permit, they must wait until they receive permanent resident status to begin a bridging program due to the financial cost. Providers of bridging programs for internationally educated nurses in Canada also commented on the financial burden related to taking bridging programs for live-in caregivers:

I've had a few international students [including live-in caregivers]... enrol in our program and the cost is almost three times.... I clearly remember one applicant whose employer even drove her to the college to attend my information session.... She spoke to

*me, and of course the most dreaded question that I ask is, what is your status in Canada? And so she said, I have an open work permit. An open work permit is still not seen as a permanent resident status. And so being an open work permit holder doesn't entitle them to domestic fees.... For live-in caregivers who are on open work permit or work permit general, it's still a barrier to pay humungous fees knowing that live-in caregivers generally still look after family back home It's basically asking them to give me your money... for the whole year and on an instalment basis. **Nurse Educator 2***

Live-in caregivers are already financially pressured due to the need to send remittances to their country of origin and the fees related to sponsoring their families to Canada. Frustrated over the number of fees they need to pay to become a nurse in Canada, the participants often commented that they are required to “pay this, pay that”, including the College of Nurses of Ontario assessment fee, tuition to attend educational programs, membership fees for educational programs, and fees to get documents from their country of origin and previous work locations. Although there is a program run by the Registered Nurses Foundation of Ontario that provides financial assistance to internationally educated nurses, live-in caregivers do not qualify for this program until they become permanent residents in Canada.

Passing Nursing Exams and Language Exams

In order to complete the nursing registration process and become a qualified nurse in Ontario, all internationally educated nurses must complete the Canadian Registered Nurse Exam or the Canadian Registered Practical Nurse Exam, as well as an English or French Language exam. As previously stated, the pass rate of nurses educated outside Ontario (including internationally educated nurses) on the nursing registration exam is much lower, at 35.3 percent

for first-time writers, than that of Ontario educated nurses, at 80.7 percent (CNO, 2013b).

Consistent with this pattern, passing the nursing registration exam was a challenge for some of the study participants. Appendix D shows the success rate of live-in caregivers on this exam.

While most had not completed the exams at the time of the interview, those who had completed the nursing registration exam required multiple attempts before passing. Some of the participants were quite anxious about writing the exam since, like other Canadians, they had only three chances to take it.

Difficulty in passing the nursing exam is compounded by the fact that live-in caregivers work many hours and are unable to study, except on weekends. Moreover, the long time live-in caregivers were separated from clinical practice (typically between three to seven years) made it more difficult to pass the nursing registration exam in Canada. The participants reported that several of their friends had failed the nursing registration exam three times and thus ended their chances of qualifying as a nurse in Canada.

Language competence further inhibited the ability of these nurses to pass the nursing exam. One former live-in caregiver who had been successful in becoming a Registered Practical Nurse in Ontario noted that she failed the nursing registration exam once, then she wrote the language exam which helped her to pass in her second attempt at the nursing registration exam. Her advice for internationally educated nurses who are in the process of becoming nurses in Ontario was to focus on improving English language skills:

I will tell them that is my experience and then give them advice on what to do first, because I have been there. Like taking the English test first.... For me, because I already took [the nursing registration exam] first but I failed, so I concentrated on doing the

English test while at the same time reviewing for my next test. So, at that time, I pass my English and after a few months, I pass my CNO. Michelle

Michelle noted that passing the language test helps live-in caregivers to pass the nursing registration exam and also reduces the length of time it takes to become a nurse in Canada. The ability to pass the language test is influenced by the experience of live-in caregivers with different languages. Olivia described this:

I want to pass this IELTS test or one of the required English test in Canada. Before, I totally said, 'Ah, I can't speak. Yeah. I'm not fluent in English now.' Yeah, so that is another factor. Some of the nurses, especially from the Middle East, they don't speak English fluently since they are confused with the language that they learn from the country that they use. Olivia

Live-in caregivers commented that after spending time in the Middle East or Taiwan, they gained added language competence in other languages (e.g., Arabic) but it also might have diminished their competence in the English language.

Negotiating Contradictory Class Mobility

Despite the challenges they faced with the nursing registration process, several of the participants struggled to retain their occupational identities as nurses by using available resources such as the free English language educational programs provided by adult learning centres and newcomer information centres in Ontario. Grace found these resources helpful:

But during that time we are caregiver, there is an adult learning centre, we enrol for the English class. We are taking that every Saturday because it's free. Grace

Several of the participants commented on the very helpful role the CARE Centre for Internationally Educated Nurses played in their integration in Canada:

*You know, last year, we contacted the CARE. You know the CARE, Care for Nurses. We talk to [name], she is a Nurse Case Manager. And she told me about the right path, how to become a successful nurse. **Amy***

The CARE for Nurses Program helps internationally educated nurses to obtain information on the nursing registration process and also acts as a formal support for live-in caregivers. While internationally educated nurses commented on the great help offered by this agency, others felt the cost (including registration cost) for attending the CARE Program was prohibitive:

*You need to pay. **Emily***

*Oh, so this [CARE registration fees] is expensive. **Danielle***

The nurse educators interviewed noted that the cost to becoming a life-time member of CARE for Nurses is a one-time fee of \$125. Moreover, website information of CARE for Nurses indicated the cost for attending ten full days of review for the Canadian Registered Nurse Exam is \$400, much less than the \$1,000 to \$1,200 charged by private exam review courses offered by the Toronto School of Health and Toronto School of Nursing. It is apparent from the wide range of nursing registration exam preparation courses available online that these courses have become a burgeoning industry.

A few of the participants found that volunteer opportunities helped them to integrate into the nursing profession in Canada:

You know I really want to go back to nursing. Now, I am volunteering in the hospital.

Grace

Volunteer work helped to connect them with valuable networks and also provided an orientation to the Canadian hospital setting. Other participants tried to find work as personal support workers once they had obtained an open work permit, however most employers wanted someone with a personal support worker certificate. Despite these challenges, some participants were able to obtain employment in a nursing home.

Live-in caregivers, including two who were Registered Practical Nurses at the time of the interview, commented on how a Registered Nurse (who introduced them to the study) mentored them and assisted them in preparing for the exam. Leah attended a presentation by a Filipina Registered Nurse and the experience of the speaker inspired her to pursue her dream in Canada. While she was in the process of gaining entry to practice as a nurse in Canada in 2004, an employee of the College of Nurses of Ontario helped Leah by updating her on the registration process and encouraging her:

There were some challenges, but there was a lady in CNO who was very, very supportive. I told her, 'you were my best ally in this'.... Yeah, very, very, very inspiring. She just inspired me. She would call me and update me on my status, where my papers are now, what to prepare and then ... and yeah, she would give me encouragement and she was happy for every success that I have.... I said, wow, that was my first taste of Canadian service, customer service, you know. This is good, this is good. And then she must have felt that, you know, I'm a live-in caregiver and know nothing about Canada. Leah

While Leah (who became a Registered Nurse in 2005) was the only participant who spoke of receiving support from the College of Nurses of Ontario, several nurses interviewed said they had received support from nursing educational service providers. Along with social support, the

three participants who were registered to practice as nurses in Canada emphasized their personal commitment and discipline as key facilitators in being able to become a nurse in Canada:

I tried to discipline myself. No cell phone, no cell phone, turn off everything. So I would put my employer at 8:00 into her TV and by 10:00 she's ready to go to bed. So [during] that time, 8:00 to 10:00, I'm by myself in the room. She doesn't disturb me, she's on the TV for two hours, that's my review time. And I don't talk to anyone on the phone, I don't know computers, I don't do that thing. I just call a few friends before, you know, before I start my review, for inspiration, encouragement. I talk to my sister. I call my family briefly and I say two hours no talking. I did my discipline. Leah

Leah relied on social support, self-discipline and a strict schedule in becoming a nurse in Canada. Together with educational programs, social support and personal commitment helped live-in caregivers to achieve their dream of becoming nurses in Canada.

CONCLUSION: EXPERIENCE IN CANADA

In conclusion, while the study participants experienced dislocations of non-citizenship and non-belonging, contradictory employer/employee relationship, the pain of family separation, and contradictions in class mobility, they also challenged these dislocations in diverse ways. There were several interlocking relations between these dislocations. For instance, the experience of being non-citizens affected their ability to become nurses in Canada and reinforced their contradictory class mobility. Due to their status of being temporary migrants in Canada, they had to pay international student fees, which were approximately equivalent to their yearly salary. Moreover, due to their immigration status, they had to work as a live-in caregiver for a

minimum of two years and hence risked their ability to demonstrate three years of recent, safe nursing practice as required for registration with the College of Nurses of Ontario.

There is a lack of alignment between their goal of becoming a nurse in Canada and the immigration path they chose to achieve this goal. While the focus of the Live-in Caregiver Program policy is to fulfil labour shortage by ensuring sufficient supply of caregivers in Canada, the goal of this group of caregivers is to become a nurse in Canada. Despite this incongruence between the individual goal of these nurses and immigration policy, and despite the warnings they received from friends about the challenges of working as a live-in caregiver, they chose to migrate to Canada through this route because it was one of the few ways to migrate to a Western developed country, especially for those without significant financial resources. Their migration path as live-in caregivers complicated the process of professional integration in Canada.

CHAPTER 8: RESULTS 3: RIGHTS AND OBLIGATIONS OF DIVERSE

STAKEHOLDERS

INTRODUCTION

Fifteen live-in caregivers and nine policy stakeholders (including one immigration policy maker, four educators of internationally educated nurses, two representatives of recruiter groups, and two representatives of support groups) participated in this study. In addition, diverse documents were analyzed to shed light on the rights and obligations of diverse stakeholders. This chapter seeks to tackle the research question: What are the views of stakeholders on the migration and integration of nurses who migrate through the Live-in Caregiver Program, especially with respect to socio-economic rights and obligations? An analysis of the rights of nurses who migrate to Canada through the Live-in Caregiver Program and the obligations of diverse stakeholders towards their socio-economic integration necessitates consideration of issues of justice for these workers. According to Nagel (2005), justice is “concerned with the relations between the conditions of different classes of people, and the causes of inequality between them” (p. 119). The cosmopolitan conception of justice, congruent to Carens’ (2008) ideas, holds that sovereign institutions are instruments of enacting justice, a duty of fairness that we owe to our fellow human beings. Carens supports the notion of justice and equity among individuals, such as live-in caregivers, who have lived within Canada for a prolonged period of time. In Carens’ view, the state has an obligation to protect such individuals and to ensure they are awarded the same standard of democratic justice as its own citizens.

Extending the work of Carens (2008), this chapter presents an analysis of the rights of nurses who migrate to Canada through the Live-in Caregiver Program and the obligations of diverse stakeholders. The chapter draws on information from Citizenship and Immigration

Canada documents, interviews with nurses who migrated through the program, and interviews with stakeholders (including immigration policy makers, educators, recruiters and support groups). This analysis includes the consideration of 1) the rights of live-in caregivers; and 2) the rights of nurses who migrate to Canada through the Live-in Caregiver Program. In the course of data collection, stakeholders identified the obligations of nurses who migrate through the Live-in Caregiver Program. Such obligations will be described, and lastly the obligations of diverse stakeholders.

LIVE-IN CAREGIVER RIGHTS

The rights of live-in caregivers in Ontario are shaped by both immigration policy and labour policy. While the Federal Government sets and enforces immigration policy, Provincial Governments set and enforce labour policy. According to Citizenship and Immigration Canada (2013f), to be eligible to migrate to Canada, the live-in caregiver must 1) complete a minimum of secondary school level of education; 2) have six months of live-in caregiver training or one year of paid work experience in “early childhood education, geriatric care, pediatric nursing or first aid”; 3) demonstrate English or French language proficiency; 4) have an open work permit; and 5) have a signed contract with an employer. The signed contract must include description of mandatory employer paid benefits (including all recruitment costs, cost of transportation to place of employment, medical insurance coverage, and workplace safety and insurance coverage), job duties, hours of work, wages, accommodation arrangements, holiday and sick leave entitlement, as well as termination and resignation terms. In addition, the employer of the live-in caregiver must have a positive labour market opinion from Human Resources and Development Canada.

Once the live-in caregiver is in Canada, employers and live-in caregivers must comply with provincial labour regulations. Two Acts that are of particular relevance to the working conditions of live-in caregivers in Ontario are the *Employment Standards Act* (Government of Ontario, 2000) and the *Employment Protection for Foreign Nationals Act (Live-in Caregivers and Others, 2009)* (Government of Ontario, 2009). The Employment Standards Act, which applies to all employers and employees in Ontario, stipulates that employers must not pay employees below the minimum wage and sets a maximum limit of 48 hours a week on hours of work, except in cases where a written agreement has been made between the employee and the employer and the agreement has been approved by the Ontario Ministry of Labour. In Ontario, a live-in caregiver employee must be paid overtime for working over 44 hours a week at a minimum of 1.5 times of regular pay, and an employer can charge a live-in caregiver \$85.25 per week for room and board (only if the employee has actually received the meals or occupied the room). Also, an employer cannot threaten or intimidate a live-in caregiver for asking about or demanding their rights and a live-in caregiver cannot agree to give up their rights as stipulated in any labour law. Moreover, the Employment Protection for Foreign Nationals Act stipulates that employers must pay all recruitment costs and transportation costs related to beginning employment as a live-in caregiver (Government of Ontario, 2009).

Despite laws that mandate the obligations between live-in caregivers and stakeholders, participant interviews revealed that such laws were frequently not followed. For instance, live-in caregivers in this study were seldom paid for the total hours that they worked. Some live-in caregivers were merely seeking payment for the hours worked, let alone attempting to recover money due for overtime hours (i.e., 1.5 times the hours worked over 44 hours). For instance, Amy was very satisfied with her employers whom she considered “very good professionals” who

treated her “almost like sisters and brothers”. Even though Amy signified to the researcher that she was getting paid “overtime”, on further probing, the researcher realized that Amy was not paid the total amount of time as set according to Ontario labour law:

Amy: *I consider myself one of the lucky girls. They were generous too. They follow the rules of the labour office....They are very good, they were up to date, they know what to do for the caregiver.*

Interviewer: *They give you overtime?*

Amy: *Yes of course.*

Interviewer: *That’s good. I mean overtime like one and half or overtime like regular pay?*

Amy: *I think regular pay. But that’s good for me. That’s enough, I don’t think of too much. Because you know, I was thinking, I’m lucky. Some other lady, it’s not good, like not getting the same as me.*

None of the live-in caregivers interviewed reported that they were getting paid overtime hours at 1.5 of the regular pay. Although live-in caregivers are not supposed to get meals deducted if they have not eaten in the home, Josephine discussed how employers often automatically deducted meal cost from the salary of live-in caregivers who had not eaten in the employer’s home:

And the question of food and experiences, it’s clear in the live in caregiver handbook that if you don’t eat a meal, they cannot charge you. But it doesn’t happen that way.

Josephine

Another common violation of live-in caregiver rights as reported by support group representatives and some live-in caregivers interviewed is the lack of privacy in the home and inappropriate/illegal termination of contract:

Actually by law, by employment standard law an employer should provide two weeks termination notice, right. And if not they have to pay the caregiver for two weeks termination pay. That's by law. ...Privacy It [the room] should be locked, it should be furnished. But most, take this note, most, I would say 75percent of the caregivers don't have locks. Those are one violation that the employer's don't do, don't really comply with. **Support Group Representative 2**

Olivia also discussed how she was wrongfully terminated by her employer. After being verbally abused by the employer and not getting paid for the hours she had worked, she demanded that the employer follow the contract. In response to her attempt to claim her rights in Canada, she was terminated by the employer. According to the Ontario Employment Standards Act, she had the right to two weeks of payment for lack of appropriate notice. However, at the time of the interview, the employer had not yet paid her (the two weeks pay) for the abrupt dismissal.

The rights of live-in caregivers and the ability to demand their rights are complicated by the live-in requirement and their lack of status as citizens in Canada. The fact that live-in caregivers must live in a home that belongs to the employer created inequalities in the home. Such inequality permeated the life of these workers as there were blurry boundaries between work and home locations, as both are within the abode of the employer. Josephine commented on the complexity in refusing an illegal work assignment due to the “live-in” requirements:

If you live in, you go beyond the working hours. You cannot say no. Its hard to say no. Its soo awkward to say no and even if you are sick, you are still there. You are down in the basement or in your room. You are still there. Its sort of, if you want to have privacy, you have to live out. **Josephine**

Josephine noted the inability to have a true sense of privacy due to the live-in requirement. She suggested the government change the Live-in Caregiver Program policy to allow live-in caregivers to live out. The immigration policy maker interviewed alluded to the live-in requirement:

We have been pushed on why the live-in.... is there truly a push for workers to live-in or not. **Immigration Policy Maker**

The immigration policy maker further added that in many countries that have domestic worker programs, there is no requirement that the worker must live-in. The rationale frequently given by policy makers, especially Human Resource and Skills Development Canada, for this requirement of the live-in caregiver is that there is no shortage of live-out caregivers. The Live-in Caregiver Program serves to fulfil the critical shortage of individuals who can provide care while living in the client's home (i.e., provide a 24 hour presence in the home). However, most live-in caregivers interviewed noted they were paid for around the same amount of time as live-out caregivers, (i.e., eight hours a day). The need to have a "live-in" caregiver may signify a requirement that the care recipient requires more hours of care than the usual eight hours a day. However, live-in caregivers were often only paid eight to ten hours a day, while they worked more hours due to their prolonged presence in the home.

Certainly, gaps exist in the rights of live-in caregivers as provided in labour and immigration laws and participants' descriptions of their experiences exercising their rights in Canada. Such gaps reveal the inequities in the status of these workers, especially their live-in caregiver status. Due to their status as temporary residents in Canada and the requirement that they live in their clients' home, live-in caregivers sometimes forfeited their legal rights in

Canada. Next, the rights and obligations of nurses who migrate to Canada through the Live-in Caregiver Program will be discussed.

**RIGHTS AND OBLIGATIONS OF NURSES WHO MIGRATE TO CANADA THROUGH
THE LIVE-IN CAREGIVER PROGRAM**

Policy makers are quite aware that nurses and trained professionals migrate as live-in caregivers. This was exemplified in a statement by the Minister of Citizenship and Immigration, the Honorable Jason Kenney, in a December 2009 Speaking Notes:

Many of them (live-in caregivers) have training as medical practitioners, as nurse assistants, and as nurses, and they come from different backgrounds. Many, if not, in fact, the vast majority, originally are from the Philippines. **Honorable Jason Kenney**

In the course of data collection, several other health care professionals inquired about the study, including one doctor who migrated to Canada to work as a domestic worker. While the rights of live-in caregivers are clear under current policies and laws in Canada, there remains a disconnection on the rights of nurses who migrate to Canada through the Live-in Caregiver Program. The stakeholders interviewed (excluding educators) were well versed on the rights of live-in caregivers in Canada, especially as stated in the Employment Standards Act and the Citizenship and Immigration Canada policy. However, stakeholders did not perceive any rights that are specific to nurses who migrate to Canada through the Live-in Caregiver Program as the purpose of admittance to Canada is to work as a live-in caregiver and not as a nurse.

One nurse educator alluded to how she frequently reminds nurses who migrate to Canada through the Live-in Caregiver Program (and have not completed their work obligations) of the need to work rather than focus on pursuing the nursing profession in Canada:

But if in the early stage I always say to clients your purpose here is to work, not to study.

Nurse Educator 3

According to immigration policy, live-in caregivers have an obligation to work in the home, to live in the client's home, and to provide care for a minimum of 24 months. Recruiter 1 described these obligations:

*Well their obligation is to work as a live-in caregiver, right, because they want to come here and they want to finish the program....So the obligation is to do such that they do qualify for permanent residence, right. The obligation is there for them to finish the 24 months to stay within the program. **Recruiter 1***

While stakeholders emphasized the obligation to complete the program and provide care, live-in caregiver participants further added that the live-in caregiver has the responsibility to be assertive. The importance of being "assertive" is important because of negative experiences and the risk of abuse and exploitation due to their immigration status. Emily also discussed the importance of assertiveness:

Well, they have to read. They have to have a copy of their contract....If you say, no, this is what's in my contract. If you do this, I'm gonna report you to the immigration or I will move out and the employers will say, 'oh my'. They're [i.e. the employer] going to have to back off....They'll say, 'oh she's not ignorant, she knows what she's talking about.'
*Then the employers will stop. I think that's the best thing. **Emily***

Being active in seeking, using and enforcing their rights in Canada was especially important for this group of internationally educated nurses in their professional integration. However, several live-in caregivers were cautious in engaging politically while working as a live-in caregiver due to their vulnerability and legal status in Canada.

Nurses who migrate to Canada through the Live-in Caregiver Program are obliged, like other internationally educated nurses, to be accountable for their process of socio-economic integration in Canada. Such accountability and obligations are required of prospective members of a regulated profession in Canada. As Nurse Educator 2 described, educators see their role as not just providing internationally educated nurses with information but also educating them on the accountability and obligations related to entry into practice as Registered Nurses in Canada. This accountability demands that the internationally educated nurse must take initiative in seeking out information. Speaking on the provision of information to internationally educated nurses, Nurse Educator 2, who is also an internationally educated nurse from the Philippines, said:

*So it's very easy to give them that answer but my reply would be I encourage you to read the information package and if you have any questions, please feel free to email me or call me. I will be pleased to find that answer for you. It happens 60-70 percent of the time, I think I should have a cad [automatic] response – 'please refer to the information package'. It's not that I don't want to give them the information. I want them to develop a sense of accountability.... We can help you do things, but we cannot do things for you. I think that's an important message that we need to get to IENs in general and live-in caregivers in particular. We will support you, but you have to do your role. **Nurse Educator 2***

Rather than seeing internationally educated nurses as passive participants in the integration process, Nurse Educator 2 sees internationally educated nurses (in general) as having a responsibility for their own learning and their own socio-economic integration in Canada. In this view, internationally educated nurses do not just respond to policies, they are also active agents

in their own socio-economic integration in Canada. The active role of internationally educated nurses in their integration is consistent with the idea described in the earlier paragraph that a facilitator to integration of internationally educated nurses in Canada is their own personal motivation in the integration process. For instance, the three live-in caregivers who were registered to practice in Canada (one as a Registered Nurse and two as Registered Practical Nurses) identified personal motivation as a strong facilitator of their success in Canada.

OBLIGATIONS OF STAKEHOLDERS

The document analysis (see Appendix A) revealed an emphasis on the obligations of employers and recruiters in the migration of live-in caregivers to Canada. Interviews with live-in caregivers and stakeholders further identified obligations of immigration policy makers, nursing policy makers, recruiters and employers. These obligations as they relate to diverse policy stakeholders are described below.

Obligations of Employers

Employers' main obligations are to abide by the policy of the Live-in Caregiver Program as well as the terms of the agreement as stated in the contract. As Josephine said, "the contract...that's the binding". However, interviews with live-in caregivers and stakeholders revealed that the contract was often not followed. Abiding by the agreement as stated in the contract is not only beneficial to live-in caregivers, but also to employers:

And families, employer families, who understand what the rules and regulations are and treat their nannies with respect have their nannies a very long time. You know, when that nanny goes, they will get great references and everybody wants that job. Recruiter 2

One obligation of employers that was viewed differently from the two recruiters interviewed is the obligation of employers to pay all recruitment fees and costs. Recruiter 2 and the association she represents (which consist of employers and recruiters) believe that mandating employers to pay will be effective in ensuring quality in the delivery of the Live-in Caregiver Program:

And so having employers pay the fee ... if it is a legitimate employer and if they legitimately cannot find someone on the local market they are willing to pay the fee for someone to come. If they're gonna get a good caregiver from overseas they're willing to pay the fee. And so that's one of the things that will help to improve the quality of care and reduce the amount of abuse. Because now there aren't fake jobs going over because families have to sign that they're gonna pay this and they're gonna pay the flight and they're gonna pay proper wages, etc **Recruiter 2**

However, Recruiter 1 strongly disagreed with the idea of obligating employers to pay the recruitment cost for live-in caregivers because there is no mutual obligation on the part of the live-in caregiver to remain with the employer:

These fees, you know, are very ... I mean they're very high. They run around three, four, or five thousand dollars sometimes and many families that need live-in caregivers are very reluctant and unwilling to risk that amount of money for an overseas caregiver they've never met and that they have no idea will do a good job, will work out, will be the right match. **Recruiter 1**

Recruiter 1 went on to describe how some live-in caregivers accept a position and leave shortly after arriving in Canada. This leaves the employer with a financial burden. This idea of

challenges with retention was corroborated by postings on a petition site which was set up by the Association of Caregiver and Nanny Agencies Canada (2012):

The process to hire a live in caregiver has become too complicated and very expensive and risky on top of it without any insurance that the caregiver will like our family. She could easily take off and move to Toronto or another major city. We would like the Government to review the program. **Employer 1**

Current policies do not support working families with young children. Wait times are too long, employers burdened with cost and there is no assurance that the caregiver won't leave for a better offer. **Employer 2**

Statements by employers (on the petition site) and by Recruiter 1 emphasize the lack of reciprocal obligations between live-in caregivers and employers. From their perspective, the Live-in Caregiver Program overly shifts the burden on obligations to employers with minimal reciprocal obligations of the live-in caregiver. However, as Recruiter 2 explained, if an employer treats a live-in caregiver with “respect” and obeys the contract, there is a very high likelihood that the live-in caregiver will not leave the employer in search of another job.

Obligations of Recruiters

Of note, beneficiaries of the Live-in Caregiver Program are not just employers, care recipients and live-in caregivers; recruiters also benefit from the Live-in Caregiver Program. Recruiter 1 and 2 stated that since the implementation of obligations of employers to pay recruitment fees, several recruiters have had to close down due to lower demand by employers:

And I'm in contact with a lot of agencies across Canada and many of them are closing down because they just no longer can keep the business ... you know, can sustain the business because families are just not willing to take the risk. I don't think we're gonna have too many nurses coming on the Live-in Caregiver Program to be honest. Recruiter

1

As indicated above, Recruiter 1's focus is on ensuring the recruitment of live-in caregivers remains a lucrative "business". Despite this recruiter's view that there may be a future decrease in nurses migrating, there has recently (since 2012) been an increase in the number of nurses inquiring about the Live-in Caregiver Program on the website www.canadavisa.com, especially after the Federal Skilled Worker Program was suspended in July 2012 and the subsequent removal of Registered Nurses and Registered Practical Nurses from the list of occupations allowed to migrate through the Federal Skilled Worker Program in March 2013.

Negative financial consequences exist for recruiters who require a high demand for live-in caregivers to sustain the business. As recruiters are active participants in the Live-in Caregiver trade, they also have an obligation to obey the rules of the Live-in Caregiver Program and to not exploit live-in caregivers. During the course of data collection, live-in caregivers spoke about their friends who had been exploited by recruiters who promised to bring them to Canada after collecting fees from them, without eventually bringing them to the country.

Recruiters also have an obligation to provide live-in caregivers with accurate information. Some nurses who migrated to Canada through the Live-in Caregiver Program expressed the belief that recruiters should have also provided them with the information that they could migrate to Canada as skilled workers:

Yeah, they should tell us if you are a nurse, you should apply as an immigrant, like that, not like a live-in caregiver because as a live-in caregiver you have to finish your 24 months. **Catherine**

On the other side, the recruiters, I should have to be thankful to her. She is the reason why I came here. She is the reason why I was here. But the thing is, well I was just thinking to her that she should tell to her applicants what are those things that we have to encounter in details. She need to be specific because she didn't give us specific things that we are going to face here when we are here...trying to become a nurse....Because the main purpose I accepted a job as a live-in caregiver is because I was thinking its just only a step to become a nurse. **Amy**

Nurses interviewed felt that recruiters themselves did not have adequate knowledge about the process of becoming a nurse in Canada. Despite the lack of adequate information from recruiters and the dissatisfaction with service provided on their long-term socio-economic integration as nurses in Canada, most live-in caregiver participants were thankful to recruiters who helped them to achieve their aim of arriving in Canada.

Obligations of Immigration Policy Makers

In this study, live-in caregivers consistently identified immigration policy makers, especially Citizenship and Immigration Canada, as having a significant obligation in their integration in Canada. The obligation to ensure faster processing time of permanent resident applications was identified by live-in caregiver participants and nursing educators:

I think they have to change the immigration rules. They have to speed up the rule because according to them, you cannot work as a nurse unless you are a permanent resident here. They will not issue your licence unless you are a permanent resident. They should start with the immigration. They have to focus more on the immigration process.... They should issue us the papers, the permanent residency. Because that is the cost that will cause us to be soo slow in the [nursing registration] assessment. Anyway we can take the exam, we can take the courses; what about our permanent resident? We don't have a lot of chances if you don't have a permanent resident in Canada. Amy

While at the time of interview (in February to October 2012), Citizenship and Immigration Canada had just issued open work permits to several live-in caregivers, lack of permanent resident status still posed a significant barrier to the long-term integration of this group of nurses. This is particularly problematic because the obligation of live-in caregivers as stated on the Citizenship and Immigration Canada website is to provide care in the home for a minimum of 22 months. However, in Irene's case, for example, she had lived in Canada for seven years and was not yet a permanent resident in Canada due to issues with the admissibility of her child who had a developmental disability. She strongly felt that the Canadian government should have provided her with a faster response concerning issues related to her permanent resident status, as well as clearly defined the parameters of inadmissibility of children with disabilities in Canada.

Citizenship and Immigration Canada recently identified the long processing time of live-in caregiver applications as problematic. In a recent speaking note of the previous Minister of Citizenship and Immigration Canada (2013g), Honorable Jason Kenney, he identified challenges with the long processing time of permanent resident applications for live-in caregivers:

Finally, let's look at another very popular immigration program, the Live-in Caregiver Program. Again, here this is one program where we have not made progress, where we do have a problem with which we will have to deal. Because of a surge of new applications in that program a few years ago, we're now sitting on a 45,000-person backlog with a five-year wait time for live-in caregivers, which is unacceptable. We have to fix this. **Minister Jason Kenney**

Educator 2 suggested that due to the time it takes from completing one's obligation as a live-in caregiver to becoming a permanent resident in Canada, Citizenship and Immigration Canada and the Ministry of Training Colleges and Universities in Ontario should allow those who have completed their work obligations to take courses at permanent resident rates. They currently pay international student fees while they are on an open work permit:

It's probably a collaboration between federal CIC [Citizenship and Immigration Canada], provincial MCI [Ministry of Citizenship and Immigration] and MTCU [Ministry of Training Colleges and Universities] to recognize open work permits for live-in caregivers as equivalent to permanent residence for education purposes so that they can avail of domestic fees. **Nurse Educator 2**

Based on the issues faced by live-in caregivers in Canada and the impact of family separation on children of live-in caregivers, Support Group Representative 1 recommended that the Live-in Caregiver Program should be discontinued. Support Group Representative 1 belongs to an advocacy group that was founded by live-in caregivers. The activities of the group are currently managed by children of previous live-in caregivers. The active participation of children of live-in caregivers has meant a critical focus, not just on the issues that are relevant to live-in

caregivers, but also on those that are relevant to their families. Support Group Representative 1 described the group's opposition to the Live-in Caregiver Program:

But our youth are very articulate in saying no, scrap it because the impacts of the LCP [Live-in Caregiver Program] goes far beyond the women under the LCP themselves. We are also impacted by it. The entire community is impacted by it. We are the future of this community and if we're feeling the impacts of the LCP this is not the future that we want and that's why they're very articulate ... because a lot of people think that if you're in the LCP the impact stays with you but the youth are saying no. **Support Group 1**

However, Catherine, Francisca, Grace, Helen, and Josephine disagreed with the idea that the program should be “scrapped”. They strongly felt that the program should be continued but modified, as it provides an alternative path to permanent residency for those who are unable to qualify through the Federal Skilled Worker Program route for diverse reasons. The Minister of Citizenship and Immigration Canada at the time, the Honorable Jason Kenney, was well aware of the two arguments for and against the continuation of the Live-in Caregiver Program but supported its continuation, noting the highly valuable work provided:

Some people would like to end the Live-in Caregiver Program. I don't think they fully appreciate the full value, the hard work, the centrally important jobs that are done by caregivers, usually women of great compassion, who give of themselves. **Honorable Jason Kenney, 2009**

Moreover, the immigration policy maker interviewed commented that in comparison to other countries with domestic worker programs, the Canadian Live-in Caregiver Program represents a “model program” with strong labour market protection policies across provinces. Since 2009, there has been no verbalized or documented support by the government on the continuation of

the Live-in Caregiver Program. However, on October 16, 2013, the Government of Canada announced plans that it will be making reforms to the Temporary Foreign Worker Program (Governor General of Canada, 2013).

Support Group 1 and Educator 2 reported that the word “live-in caregiver” masks the duties these workers do in the home:

They don't think they'll be doing housework, they think more that they'll be private nurses. **Support Group 1**

The name of the program paints a picture that these nurses will be providing “care” work, a central component of nursing. However, as Nurse Educator 2 identified, they become “deprofessionalized” on arrival in Canada as they do not work in their profession for a significant period of time:

So they become deprofessionalized, they lose their skills.... From a nursing perspective when they come into our program they seem to have forgotten about nursing. There is that keen desire to become nurses again, but they seem to have lost the knowledge and skills that they previously learned from their programs and that's a big challenge. My heart goes out to these IENs regardless of their country of origin because you can see how much they worked for. And some of them actually approached me and said, [name], 'I don't know these any more, I haven't worked as a nurse for more than ten years'.

Nurse Educator 2

Obligations of Nursing Policy Makers

Due to the loss of essential nursing skills that occurs after being away from clinical practice for a period of time, in January 2013, the College of Nurses of Ontario implemented a

policy that mandates all nurses to demonstrate three years of recent safe nursing practice. Previously (and at the time of data collection), nurses in Ontario had to demonstrate five years of recent safe nursing practice. This change from five years to three years has major impact on nurses who migrated as live-in caregivers as they must complete the Live-in Caregiver Program before they can register as nurses in Canada. The Live-in Caregiver Program takes a period of two to four years plus another one to three years to become a permanent resident. What this means is that beginning in January 2013, almost all live-in caregivers would need to take two years or more of retraining to become a registered nurse in Ontario since they will be unable to demonstrate three years of recent safe nursing practice. Although live-in caregiver interviews occurred between February and October 2012 (two to ten months before the implementation of this change), no live-in caregiver interviewed was aware that the change would be made in January 2013. In response to changes that had been made in the past that affected internationally educated nurses, Olivia expressed the view that the nursing regulatory body in Ontario has an obligation to provide adequate notice and time, prior to the implementation of changes.

In addition to providing significant time and notices to internationally educated nurses before making changes to the nursing registration process, live-in caregivers interviewed noted that the College of Nurses of Ontario should ensure consistency in the assessment of qualifications. Some participants described how their qualifications were assessed differently to those of their peers who had graduated from the same educational institution with the same degrees. Another obligation of nursing regulatory bodies is to have adequate knowledge of nursing regulatory policies in different countries. For example, participants felt that a more adequate knowledge of registration and credential verification process in Saudi Arabia and in

Libya will further ease their registration process and may allow them to be assessed appropriately as a registered nurse, instead of as a registered practical nurse.

Obligations of Educators

Educators felt that they had an obligation not only to ensure that internationally educated nurses pass the licensing exam but that they are also able to provide competent and safe nursing care:

When we were evaluating our program, the feedback we received was just tell us what we need to know. Yeah. That's the thing again, it's easy to help them pass probably, you just run through the blueprint of the CPNRE, 'okay, here it is', but it's more than that....I would always tell my students we could probably help you get your registration very quickly, but you could probably lose it as quickly.... Yeah, that becomes a public safety [issue]. **Nurse Educator 2**

Nurse Educator 2 alluded to the role of educators that goes beyond helping internationally educated nurses to pass the nursing registration examination to ensuring that they are competent in providing safe and effective nursing care. However, the lengthy period of not practicing as a nurse makes it difficult for educators to integrate this group of nurses.

CONCLUSION

In conclusion, the rights of live-in caregivers are shaped by both immigration policy and labour policy. However, due to the status of these workers as non-citizens and the spatial inequities within the home, the implementation of such labour rights is problematic. Moreover, there is currently a disconnection between immigration policy and nursing policy as it relates to this group of workers. While the government recognizes that nurses migrate through this route,

no policies or information exist to support these workers, as their initial obligation in Canada is to work as live-in caregivers. Hence, what exist are the divergent obligations between three statuses: status as a live-in caregiver, status as nurses, and status as eventual permanent residents in Canada. While the Canadian government is focused on the short-term obligation of meeting labour market need (especially addressing the shortage of live-in caregivers), the live-in caregivers interviewed emphasized the long-term obligation of ensuring their integration as nurses in Canada, in addition to gaining permanent resident status. However, given that the Live-in Caregiver Program does involve a pathway to permanent residency, some thought should be given to prepare these workers for labour market integration and the recognition of their qualifications. This would be in line with Canada's goal of long-term economic integration of permanent residents in Canada. Furthermore, live-in caregivers must be cognizant of their initial obligations to fulfil labour market need in Canada.

In sum, interviews and document analysis identified obligations of all stakeholders. Employers have several obligations under Canadian law, as set out in immigration and labour policies. In addition, live-in caregiver and support group participants noted that the Canadian government has an obligation to grant permanent residency to eligible live-in caregivers immediately after live-in caregivers have completed their contractual obligation. Participants noted that it is the obligation of nursing policy makers to ensure that internationally educated nurses are given enough time to prepare for changes to nursing registration requirements and to be aware of nursing regulation policies in other countries. Finally, recent changes to entry into practise that require the demonstration of safe nursing practice within the last three years by all nurses in Canada, and the high likelihood that live-in caregivers will not be able to achieve this

goal, create a strong need to ensure congruence between health human resource and immigration policy.

CHAPTER 9: DISCUSSION AND CONCLUSION

INTRODUCTION

Philippine educated nurses migrate to Canada through the Live-in Caregiver Program to provide care to the elderly, the sick, children, and the disabled, while living in the client's home (Philippine Women Centre, 2001; Zaman, 2006). My doctoral thesis sought to explore the reasons why Philippine educated nurses migrate to Ontario through this path, the pre-migration expectations of this group of nurses, the experience of these nurses in Canada, and the obligations of stakeholders towards their socio-economic integration. My study utilized a case study design, employing qualitative methodology, and the concept of global care chains to shed light on the issue of nurse migration to Canada through the Live-in Caregiver Program. Findings from my thesis illustrate the transfer of care work across nations and the role of familial ideologies and global inequities in structuring the experience of this group of internationally educated nurses. This chapter summarizes the research findings and provides depth to the analysis in light of the literature, and discusses the new knowledge gained. First, the chapter provides insight into the two-step migration pattern of these Filipina nurses, including the role of gender and social class position in structuring the participants' migration path. Next, the chapter discusses the labour these women engage in, especially the role of emotional labour in structuring their experience. The emotional aspect of working with an employer and care recipient is discussed, as well as the discourse of being "one of the family". The third section describes the nursing integration experience of this group of nurses, while the final section describes the obligations of diverse stakeholders. Limitations of the study and selected implications for policy and future research are provided.

INFLUENCE OF GENDER AND CLASS IN TWO-STEP MIGRATION

This section of the thesis describes the process of migration of this group of nurses, which often involves a two-step migration process. Gender and class further structure the migration experience of these nurses, as they sacrifice their career prospects in an attempt to gain citizenship for the family in Canada and to increase their global social position.

Two-Step Migration: Philippines to the Middle East to Canada

According to the participants, the process of migration of Philippine educated nurses to Canada through the Live-in Caregiver Program begins before prospective nurses enter nursing schools in the Philippines. Helen's story illustrates how she was encouraged to enter nursing to fulfil her parent's dream of having a daughter working outside the Philippines who could send remittances to the Philippines for the family's benefit. The focus on training of nurses in the Philippines for export has been well documented in the literature (Choy, 2007; Lorenzo et al., 2007). Individuals are motivated to enrol in nursing schools to increase their chances of being able to migrate out of the country, and subsequently remit to their families at home. The remittances sent home by the participants in my study provided more than subsistence relief for their families. In fact, several of the nurses funded a servant or helper for their families in the Philippines. In this way they join other migrant workers to become "national heroes" due to their economic contribution to the Philippine economy. Such a culture of migration and national heroism motivates young women to enter into nursing, even with a bleak nursing job market in the Philippines. However, this heroism comes at the expense of their personal downward occupational mobility and family separation (Rodriguez, 2002).

There is a well-established migration chain from the Philippines to the Middle East (especially Saudi Arabia) and then to Canada, which is facilitated by informal networks such as

family and friends, as well as recruitment agencies. The majority of participants in my study knew someone in Canada (pre-migration) who facilitated their immigration process. According to Yeates (2005), networks of labour including employment agencies operate through formal and informal networks, such as family and friends. The role of family in facilitating migration is strong as over 50 percent of live-in caregivers are destined to work in the household of family members (Gardiner-Barber, 2008). McKay (2002) found that family members in Canada often assisted relatives whom they were unable to sponsor as family members by finding them an employer in Canada. However, in some cases, this employer is a fabrication or has to be paid for their “service”, similar to the case of being “released on arrival” as discussed in my study. Hawkins (2013) also found that internationally educated nurses (including those who migrate as live-in caregivers and skilled workers) were often encouraged by family members in Canada and friends in the Middle East to migrate to Canada. Recruiters interviewed in my study described how they are often recommended to prospective migrants by family members and friends who are already in Canada. Indeed, family members and friends appear to be an important element in the global network of recruiting workers to Canada.

Step-wise migration is a common finding in my study. Fourteen of the fifteen women had experience working in a country outside the Philippines (often in the Middle East). Eleven of these nurses migrated directly from another country (i.e., engaged in two-step migration) before coming to Canada, while three had experience in another country but migrated to Canada directly from the Philippines. Recent studies are beginning to shed light on the two-step migration process for Philippine educated nurses who migrate as Live-in Caregivers (Hawkins, 2013; Walton-Roberts & Hennebry, 2012). The preliminary results of a similar study that was conducted in Ontario at the same time as my research, which included 28 Philippine educated

Nurses, nine of whom migrated to Canada through the Live-in Caregiver Program, also found that some Philippine educated nurses had a two-step migration pattern (Walton-Roberts & Hennebry, 2012). In Walton-Roberts and Hennebry's (2012) study, the predominant last country of residence was the Philippines (19 participants) and Saudi Arabia (5 participants). The higher representation of the Philippines as the last country of residence in Walton-Roberts and Hennebry's (2012) study as compared to my thesis may be explained by the fact that not all individuals interviewed in their study had migrated through the Live-in Caregiver Program. Moreover, Hawkins (2013) also found stepwise migration (mainly from the Middle East) common among nurses who migrate to the province of British Columbia through the Live-in Caregiver Program. In line with my study, Hawkins (2013) identified that nurses often use other countries as well as the Live-in Caregiver Program as a "stepping stone" for easier access to work as nurses in Canada.

Gendered Sacrifice: "All for the Family"

"All for the family" was the most commonly used phrase in interviews with my participants, especially upon questioning live-in caregivers about their reasons for migration. Participants described how they were able to achieve a higher financial status (economic gain) while working in the Middle East, but lacked citizenship rights. Of the fifteen participants interviewed, thirteen had children. At the time of the interview, nine were married while the remaining participants were in a relationship (n=1), separated (n=1), or single (n=4). In search of full incorporation into the host society, the main appeal of the Live-in Caregiver Program for my participants relates to the ability to gain full Canadian citizenship for the family, as well as to achieve a higher social status and a more favourable social condition or life style (including

access to educational opportunities for children and religious freedom). Certainly, based on transnational mobility to gain citizenship for the family, the findings of my thesis are in line with a statement by McKay (2002) that Canada is “becoming a ‘graduate school’ for domestics where the goal of their migration is not the possibility of remitting money immediately but citizenship, access to the broader job market, and a chance to reunify their family” (p. 18). By “graduate school” she means the increasing trend that live-in caregivers have had work experience in another country before migrating to Canada. Similarly, Alonso-Garbayo and Maben (2009) found that the appeal for the emigration of Philippine nurses from Saudi Arabia to the United Kingdom was to achieve a better social status, religious freedom, and gender equity.

The focus on “all for the family” illustrates a willingness to temporarily sacrifice to ensure the (social and economic) well-being of the family. However, paradoxically the family also suffers to some extent given the distance created by family separation for a minimum of two years. In line with findings from my study, Hugo (2005) found that skilled Asian women accept unskilled work in order to migrate and earn money for the family. By reinforcing their gendered role, Philippine educated nurses interviewed for my study emphasized economic and social gains for their family rather than their own individual career gains. Such focus indicates the collectivist orientation of these women. Indeed, the idea of familial sacrifice pervades their immigration decision (Gardiner-Barber, 2008).

Given the demand in the transnational economy for reproductive labour, domestic workers create transnational families to maximize opportunities and resources in the global economy for both their children and husbands (Parrenas, 2001). The live-in caregivers in my study often focused their discussion on the benefits of migration to their children. As Parrenas (2001) argued, their migration pattern involves the extension of their “mothering” role across

borders. Participants interviewed indicated they fulfilled the role of breadwinner for the family by sending remittances to the Philippines. Remittances are used by their husbands and children to sustain a more comfortable lifestyle in the Philippines. After becoming permanent residents in Canada, they are able to sponsor both their children and husband; thus they enable all members of their nuclear family to become Canadian citizens. The role of Filipina women in my study as the breadwinner for the family is contrary to traditional nuclear familial gender ideologies where men are supposed to sustain the family economically while women engage in reproductive care (Parrenas, 2001). By emphasizing the benefits of migration for their children, they bring to the foreground their traditional gendered responsibility for reproductive care. However, the benefits of their migration for the husband they left behind in the Philippines still remain as they send remittances to them and provide an avenue for Canadian citizenship for their husband. By migrating to gain citizenship for the family and to sustain the household economically while extending their mothering role across borders, these women reconstitute the gender roles within the family (Parrenas, 2001). These observations resonate with my findings; however, in my study the participants still emphasized the prevailing discourse of their reproductive role.

Contradictory Class Mobility and Discourse on Social Position

All participants interviewed had earned a baccalaureate in nursing in the Philippines. Fourteen of the fifteen live-in caregivers interviewed had experience working as a nurse (or volunteer nurse) in the Philippines. On migration to Canada, they worked in the home providing both skilled and unskilled care to children, the elderly, the sick, and the disabled. Parrenas (2001) defines contradictory class mobility as a simultaneous decrease in social status and increase in economic status resulting from the migration of domestic workers across the globe. The findings

of my thesis illustrate how educated nurses in the Philippines migrate to Canada and increase their economic status, while paradoxically decreasing their social status by working as live-in caregivers. Furthermore, similar to Parrenas' ideas, my doctoral thesis found that the relatively privileged position of these women as educated nurses eased their ability to migrate to Canada as recruiters reported favouring nurses to work as live-in caregivers.

Consideration must also be given to the experiences some of the nurse participants had in the Middle East. Twelve of the participants interviewed had nursing work experience in the Middle East. My thesis found economic advancement to be a primary motivator for emigration of these nurses from the Philippines to Saudi Arabia, but not for migration from Saudi Arabia to Canada. Philippine educated nurses interviewed noted that they either received the same salary on migration to Canada from Saudi Arabia or received a slightly lower salary in Canada. Moreover, in Saudi Arabia, nurses noted that they enjoyed several economic related benefits such as free yearly flights from Saudi Arabia to the Philippines, free housing, and two months' vacation. Hence, the motivation for migration of nurses from Saudi Arabia to work as domestic workers in Canada cannot be explained solely from a purely economic lens.

In addition to the quest to gain citizenship for the family, global inequities and differences in perceived view of the destination country influenced the view of these nurses with respect to their social status. In line with the view of family members in the Philippines, these nurses viewed working in Saudi Arabia as having a lower social status than working in Canada, regardless of the job performed or the financial compensation. Global social status served as a motivation despite receiving minimal or no economic benefits. Therefore, while caregivers decrease their perceived social status in Canada, they increase their perceived social status at home because they are seen as having access to a much better country. Helen expressed this:

But my mom was saying you go there. Because its different when you are in the Philippines or in Saudi Arabia. Once you came here in Canada and the US, you are big time already. **Helen**

Moreover, these live-in caregivers are able to achieve a higher lifestyle for their families in the Philippines due to their earnings, with some hiring a servant. Hence, in this sample, there is a global link in paid care work, where a live-in caregiver provides care to an employer's family while her family receives care from a domestic worker (or "servant") in the Philippines, funded through remittances, a case of the "Global Care Chain" as described by Arlie Hochschild (2000). Within this global system of transfer of care work, by hiring a domestic worker in the Philippines, live-in caregivers sit in the second (middle) tier of a three tier system in the transfer of care work, while women in developed countries represent the upper tier and domestic workers in the Philippines represent the lower tier (Parrenas, 2001).

In this way, participants' view of their social position represents a discourse as it is situated within systems of meaning, based on power axes across the globe. Live-in caregivers in my study resisted their downward mobility by emphasizing their higher social status (by virtue of living in Canada) as compared to women in the Philippines and their colleagues in the Middle-East. The frame of reference they utilized in analysing their social status was as viewed by their family members in the Philippines rather than as viewed by Canadians.

LABOUR AND EMOTIONAL LABOUR IN LIVE-IN CAREGIVER WORK

The participants described their experience of working with two parties: the employer, and the care recipients. Care recipients may be children, the elderly, and the disabled, while the employers may be working parents or the adult children of elderly individuals who provide the

necessary financial compensation for the labour rendered. Previous research on live-in caregivers tends to overly emphasize the negative relationship with employers without consideration of the experience of this group of workers with recipients of care (Philippine Women Centre, 2001; Zaman, 2006). Indeed, Gardiner-Barber (2008) cautions against an overly positive or overly negative view of Philippine migration to Canada, but alludes to the need to unravel the complexities related to migration. Such complexities are situated within the policy context of the Live-in Caregiver Program, including the mandatory live-in requirement. Based on the findings from document analysis, live-in caregiver and stakeholder interviews, this section sheds light on the experience of live-in caregivers in Canada, including the issue of emotional labour. First, the section describes how prospective live-in caregivers construct themselves as an emotional tool before migrating to Canada. The second section describes the emotional labour in which they engage in the home. This is followed by a discussion of the emotional displacement of love to the children and elderly they care for in Canada, and lastly the discourse on being “one of the family” is described.

Pre-Migration Constructions of Labour

My thesis found that in order to migrate to Canada through the Live-in Caregiver Program, prospective migrants often portrayed their caring self and marketed the emotional work they can do in the home, especially their ability to engage in both surface and deep acting as described by Arlie Hochschild (1983). The literature points to the grooming of domestic workers before migrating to their destination country, including Hong Kong, United States and Canada (Constable, 2007; Parrenas, 2001; Pratt, 1997). Pratt (1997) illustrated how the deskilling of domestic workers begins before they arrive in Canada, with live-in caregivers from the

Philippines being socially constructed as servants. The finding from my thesis further illustrates how such constructions include the willingness by domestic workers to engage in emotional labour, and the ability to self-sacrifice for their employers.

Illustration of the willingness to engage in emotional labour is depicted in advertisements made online by live-in caregivers, as a core value proposition in self-marketing. As Marietta who posted on TLC Edmonton, wrote, “the patient I worked with over the years have truly become a part of me...I am ready and looking forward to learn a new daily routine that is tailored to my future employer”. Irving Goffman (1959) illustrates how the presentation of self “helps to define the situation, enabling others to know in advance what he will expect of them and what they may expect of him” (p. 2). While the above depiction of a willingness to engage in emotional labour helps to market the live-in caregiver and seeks to increase the chance of being hired, it also underlines the importance of the live-in caregiver’s ability to attune her emotion to the employer’s needs (Hochschild, 1983). Similar to Irving Goffman’s (1959) perspective, Gardiner Barber (2008) describes this documented emotional display and self-marketing by prospective live-in caregivers as a “performance of subordination” where skilled Filipina workers may present themselves as “demure, subordinate maids” (p. 1274) who are able to provide some skills that employers require but also remain under the control of their employers. Such portrayals and presentation of the self as being able to self-sacrifice may predispose these workers to emotional exploitation upon arrival in Canada.

Emotional Labour in Live-in Caregiver Work

In the quest to gain Canadian citizenship, some participants sacrificed their well-being by working with an abusive or exploitative employer. For these live-in caregivers, the willingness to

remain with such employers was due to the fear that they would not be able to find an employer in time to complete the required 3900 hours for permanent resident status in Canada, which must be completed in less than four years. Furthermore, dubious recruitment agencies who recruit live-in caregivers to work for fake employers in Canada expose these women to forms of exploitation. Although only four live-in caregivers experienced abuse, my study found that individuals who were “released on arrival” on migration to Canada had added pressure to remain with exploitative or abusive employers, as they have limited employment choices while they are under enormous pressure to complete the required 3900 hours to transition from the Live-in Caregiver Program to being a permanent resident in Canada. Similarly, a doctoral thesis completed in Ontario by D’Addario (2013) found that being “released on arrival” is quite common among live-in caregivers in Ontario. According to the recruiters interviewed for my thesis, while some are aware that they will be released on arrival in Canada, others are not. On arrival in Canada, individuals who are “released on arrival” have no job and must find an employer as quickly as possible, or else face the threat of deportation. Danielle and Nannette experienced the challenge of looking for employers on migration to Canada and had negative experiences with their employers. For instance, Danielle noted how her employer often used emotional blackmail by stating that she helped her, by hiring her when she had no job, whenever Danielle tried to claim her rights in Canada.

Moreover, the work that nurses who migrate as live-in caregivers are engaged in often creates emotional strain for this group of workers. On migration to Canada, live-in caregivers interviewed discussed how they engaged in unskilled work in the home, such as cleaning the toilet. Several of the live-in caregivers interviewed described crying while they were performing what they considered to be degrading domestic work. Cleaning the toilet appears to consciously

awaken this group of women to their contradictory class status, including their downward occupational mobility in Canada. This further accentuates the psychic trauma of such experiences. In addition, commenting on the unskilled work they did in the home, several live-in caregivers interviewed for my thesis described how they moved from being a “professional” to being a “servant” or “slave”. This downward occupational mobility represents a symptom of the unequal relations between sending (i.e., the Philippines) and receiving (i.e., Canada) countries (Sassen, 1997). Driven by the inequities in global restructuring, this group of workers moved from being skilled health care workers to “servants of globalization” (Parrenas, 2001).

Another pressure to sacrifice one’s emotions and well-being is partly due to the requirements of the Live-in Caregiver Program, which necessitates live-in caregivers to work and live in the employer’s home. My thesis found that by working and living in the home of their employers, live-in caregivers found it difficult to resist the exploitation of working unpaid overtime. As Stacey (2011) alluded to live-out home caregivers in the United States, “for aides working in the home, the boundaries between work/home and public/private space are fundamentally blurred, which in turn shapes the way aides provide and interpret their care” (p. 11). Such blurry boundaries in home care are further intensified for live-in caregivers, where home becomes work and work becomes home. It exposes home caregivers to both formal and informal sets of interactional rules which are akin to the client’s family relations (Stacey, 2011). It further distorts the boundaries between personal and professional for live-in caregivers and their employers.

Being non-citizens, live-in caregivers are cognizant of the risk and uncertainty of becoming a permanent resident in Canada (Stasiulis & Bakan, 2005). Based on their status as non-citizens in Canada and akin to the power relations within the home, live-in caregivers in my

study negotiated their status by engaging in both surface and deep acting. Hochschild (1983) and Goffman (1959) described surface acting as the control of one's body language and expression based on one's ascribed social role while deep acting is the control of one's feelings based on that ascribed social role. Surface and deep acting display was evidenced by the live-in caregivers' response to employers using the "silence mode", as Helen stated. Being silent is a form of performance (Goffman, 1959) as well as emotional labour (Hochschild, 1983). Live-in caregivers were aware of the unique role that employers play in ensuring they become citizens in Canada and were often not fully aware of their rights in Canada. Hence, for them to survive their role as live-in caregivers in Canada, they had to engage in surface and deep acting by being quiet when employers were abusive to them and control both their outward expression and their feelings. Researchers have found that emotional labour leads to emotional exhaustion, job stress, burnout, and decreased job satisfaction (Brotheridge & Grandey, 2002; Pugliesi, 1999). Of particular note, three live-in caregivers interviewed in my thesis who stated that they were abused and responded by not responding or challenging the employer's behaviour identified that they were stressed and depressed while working for their employer.

Several experienced live-in caregivers described how it is essential that live-in caregivers must be assertive when dealing with an abusive employer. This is especially important for Philippine educated nurses who migrate as domestic workers and live in the employer's home as employers exert influence over their integration in Canada. On migration to Canada, live-in caregivers learn their need for assertiveness through informal networks, including friends in weekend homes and through support and advocacy groups. Palmer (2010) also found that live-in caregivers utilize weekend homes to challenge their status in Canada and to create independent spaces of belonging. This is similar to Parrenas' (2001) idea of the creation of spaces of

belonging in churches, bus stops, and train stations by domestic workers in Rome and the United States. For instance, my study found that by staying together in the same weekend homes, Catherine and Grace mentored Helen on her rights in Canada and how to survive as a live-in caregiver. During the interview, Helen referred to Catherine as her “mother” in Canada. In addition, when Helen discussed the negative experience she had with her employer, Catherine emphasized that she needed to be “assertive”. Her emphasis on being assertive was intended to guide Helen to claim her rights in Canada and to challenge an abusive employer. Such spaces of belonging enabled live-in caregivers to reformulate new identities in Canada, develop social networks (Parrenas, 2001), and develop familial bonds as Filipina women, contrary to the identities many have as “servants” or “slaves” in the employer’s home.

Emotional Displacement of Love

Consistently, participants described having positive relationships with recipients of care, including children, the elderly, and the disabled. This is contrary to the aforementioned negative relationship some participants had with employers. Moreover, two live-in caregivers described how they thought about leaving an abusive employer but remained because of the positive relationship or the “love” they had for the individuals they provided care to. The emotional displacement of love from one child in a developing country to another child in a developed country represents what Hochschild (2004) described as “emotional imperialism”. Emotional imperialism illustrates the extraction of care and love from the South (i.e., the Philippines) to the North (i.e., Canada). In the absence of their children in Canada, live-in caregivers give the children and elderly they provide care to in Canada what they cannot give to their own children and parents.

In line with Parrenas' (2001) view, emotional displacement was also a strategy used by the live-in caregivers in my study to challenge the pain of family separation. Live-in caregivers discussed how they took great care of the children they provided care to in Canada as if the children were their own. This transfer of care work and love, while someone else took care of their children in the Philippines, is a good depiction of global care chains (Hochschild, 2004). Participants in my study described how they showered the children they took care of with love and provided them with the protection that they could not provide for the children they left behind in the Philippines. In this way, participants interviewed for my study engaged in a global transplant of love or what Hochschild (2004) referred to as a "global heart transplant" (p. 22). The emotional imperialism is even much stronger when one considers the fact that immigrant women interviewed in my thesis were professional nurses in their country of origin. Moreover, as a consequence of this family separation and transfer of love, in line with Hawkins' (2013) study, some live-in caregivers in my study experienced a strain in the relationship with their children upon family reunification.

Familial Discourse: (Not) One of the Family

The blurry boundaries between work and home (and vice versa) shape the relationship between live-in caregivers and employers as well as familial discourses within the Canadian home. Such familial discourse masks the power relations between employers and live-in caregivers and renders the exploitation within familial obligations less visible (Bakan & Stasiulis, 1997). The exploitation resulting from being considered a family member (vs. employee) has been widely discussed by authors and researchers on domestic worker migration (Bakan & Stasiulis, 1997; Constable, 2007; Parrenas, 2001). As Bakan and Stasiulis (1997)

argue, live-in caregivers are “not part of the family”. Similar to findings from my study, Bakan and Stasiulis noted that employers will often use the sentiment of being “one of the family” to further exploit live-in caregivers, mainly through requiring unpaid labour. For instance, Danielle was often treated “like a family” by her employers by demanding she performed work that was not stated in her contract and by insisting that she worked unpaid overtime (contrary to her contract).

Within this context, Parrenas (2001) argues that live-in caregivers can use the sentiment of being “one of the family” to further challenge their dislocations in the home. Similar to Parrenas’ ideas, my findings indicate that some live-in caregivers welcomed being treated like one of the family to emphasize the humane aspect of their lives within the spatial zone of their employer’s home. For instance, Kristine likened being treated like an employee (e.g., by not being allowed to eat together with the family) to being treated like a “slave”. Kristine felt that being told to stand and serve the family while the family was eating was inhumane. On the other hand, Danielle expressed that by emphasizing that she was “one of the family”, the employer exploited her by not paying her for all hours worked and the employer also abused her. The idea of being treated like a “slave” represents a dichotomy as Kristine (whose employer emphasized that she was an “employee”) and Danielle (whose employer emphasized that she was “one of the family”) both described being treated like a “slave”.

The similarity between Kristine’s and Danielle’s stories is the inhumane aspect of their treatment and issues of exploitation (especially in Danielle’s case). My thesis found that domestic workers who were treated well by employers often liked being regarded as part of the family, when such familial discourse does not result in exploitative behaviours towards the live-in caregiver. When the sentiment of being “one of the family” implies respect for live-in

caregivers and a non-exploitative or abusive relationship, it can be useful for live-in caregivers in challenging the dislocation of the feelings of non-belonging. As Stacey noted, being “one of the family” helps reinforce identity formation on the job. It created a sense of collective and familial identity for those who are treated well by their employers, especially in the absence of family members in Canada. However, it could have the reverse impact on others.

NURSING WORKFORCE INTEGRATION

There remains limited data globally on the migration of nurses to work as domestic workers in destination countries. The findings from this research illustrate contradictions in class mobility as nurses migrate to Canada to work as live-in caregivers and simultaneously increase their perceived social status in the Philippines (by virtue of being in Canada) but decrease their social status and income in Canada. The downward occupational mobility represents a symptom of the unequal relations between the sending (i.e., the Philippines) and receiving (i.e., Canada) country (Sassen, 1997) as well as a form of emotional imperialism (Hochschild, 2004).

Although there is limited research on the migration of nurses to destination countries to work as domestic workers, several researchers have explored the integration of internationally educated nurses into the health care system in destination countries. Barriers identified in the literature to the integration of internationally educated nurses in Canada include: language and communication, getting documents from the country of origin, passing the national exam, passing the English language exam, cost, and discrimination (Bauman et al., 2006; Hawkins, 2013; Jeans et al., 2005). While my thesis produced similar findings on the challenges faced by internationally educated nurses, several new insights were gained on the experience of this group of internationally educated nurses in integrating into the health care system in Canada. These

included the role of familial obligations in structuring their integration experience, the strong role employers played in ensuring integration of this group of nurses in Canada, additional barriers with credential assessment, and access to bridging programs. Additional barriers to workforce integration faced by nurses who migrated to Canada through the Live-in Caregiver Program resulted from policies of the Live-in Caregiver Program, including their initial non-citizenship status in Canada. The discussion in this section will be focused on new insights gained rather than issues that have been extensively discussed in the literature such as challenges in passing exams and discrimination.

Familial Obligations

In addition to the barriers that relate to the policies of the live-in caregiver program, a paramount challenge for the participants in my study was the choice of immigration route in the quest to gain citizenship for the family. Consistent with the findings of Ronquillo, Boschma, Wong, and Quiney (2011), Hawkins (2013) and Walton-Roberts and Hennebry (2012), I found that these nurses were motivated to enter nursing in the Philippines to obey the advice of parents and fulfil their financial obligations to their family. This family commitment extended to their migration path and integration in Canada; so they may delay their career goals in order to fulfil their commitment to ensure their family is together in Canada and to meet their socio-economic needs (Hawkins, 2013; Ronquillo, 2012). Similarly, researchers in Alberta have found that motherhood remains a priority for internationally educated nurses in Canada as they emphasize their socio-economic commitment to their family rather than their own career advancement (Salma, Hegadoren, & Ogilvie, 2012).

Employer's Role in Integration

Live-in caregiver participants interviewed for my thesis identified the strong role their employer played in ensuring their integration in Canada. Supportive employers played a role in connecting nurses who migrated through the Live-in Caregiver Program to vital networks and providing additional opportunities for professional development. Several researchers have identified the abuse and exploitation that live-in caregivers face (Philippine Women Centre, 2001; Pratt, 1999; Zaman, 2005). In my research, the experience of abuse (n=4) and exploitation (n=15) contributes negatively to the professional integration of this group of nurses in Canada.

Even live-in caregiver participants who had positive relationships with their employers discussed the ambivalent stance of employers on being supportive of a live-in caregiver career plan as it contradicted their goal of retaining the live-in caregiver. The goal of all fifteen live-in caregivers interviewed was to work in a hospital after the completion of their Live-in Caregiver Program obligations, and not in home care. While this raises the issue of retention of live-in caregivers, it also raises the issue of the workforce integration of these workers. The immigration policy maker interviewed identified this issue of retention as particularly a challenge while nurse educators identified the issue of nursing workforce integration. While retention in live-in home care reinforces the shunting of immigrant women to low value care sectors, a symptom of global capitalism (Sassen, 1997), the integration of these workers as professional nurses in destination countries challenges this downward occupational mobility. Workforce integration minimizes the exploitative effects of the Live-in Caregiver Program and the negative influence of global and structural inequities on the experience of this group of internationally educated nurses.

Credential Assessment and Recognition

Credential assessment has also been identified in the literature as a major challenge to the integration of internationally educated nurses in their destination countries. However, the emphasis in the literature is on procuring documents (especially educational documents) from the country of origin (Jeans et al., 2005; Newton, Pillay, & Higginbottom, 2012). My study shed light on a two-step migration pattern and emphasizes that a greater challenge for this group of live-in caregivers is getting documents from the Middle East. All nurses who had work experience in Saudi Arabia commented on their inability to get the information and documentation that the College of Nurses of Ontario required to acknowledge their work experience in Saudi Arabia. Participants noted that after five years of not working for a specific institution in Saudi Arabia, they were unable to receive documentation of their work experience at that institution. This is more of a challenge for live-in caregivers as it takes between three and seven years to become a permanent resident in Canada and become eligible for registration.

Another issue with credential assessment identified by participants is the difference in assessment based on school and year of graduation. Beginning in 2005, entry into practice criteria for Registered Nurses in Ontario were changed to four-year baccalaureate equivalence, and for Registered Practical Nurses two-year diploma equivalence. Some live-in caregivers interviewed identified how their qualifications were assessed to be equivalent to Registered Practical Nurses (diploma) while their friends who also migrated from the Philippines were assessed to have the educational equivalence of a Registered Nurse (degree). All nurses interviewed for my thesis had completed a four-year baccalaureate degree in the Philippines. This difference in credential assessment resulted in a downward occupational mobility after the completion of the Live-in Caregiver Program. Indeed, Philippine educated nurses are

increasingly becoming registered as Registered Practical Nurses rather than Registered Nurses in Ontario (College of Nurses of Ontario, 2013c).

Congruent with the downgrading trend in credential assessment, Valenzuela and Caoili-Rodriguez (2008) as well as Brush and Sochalski (2007), point to issues of quality in educational programs in the Philippines. With the increase in nursing educational programs in the Philippines, there has been a corresponding decline in the quality of nursing education programs (Brush & Sochalski, 2007; Masselink & Lee, 2010). According to Valenzuela and Caoili-Rodriguez (2008), there is a wide range in the quality of educational programs in the Philippines due to the low percentage (19%) of higher education institution programs undergoing accreditation. Further contributing to issues of quality is the focus on production for export and the lack of adequately trained faculty members (Brush & Sochalski, 2007). In fact, there has been a decrease in nursing exam success rate in the Philippines due to the poor quality of several educational programs. These issues of quality assurance may contribute to the differences in the assessment of qualifications of these internationally educated nurses upon arrival in Canada. Moreover, educators interviewed for my study alluded to the fact that one of the reasons for the assessment of degrees from the Philippines as having a diploma equivalency is that elementary and secondary education in the Philippines is a 10-year program rather than a 12-year program as in Canada. Beginning in 2012, the Philippine government implemented a 12 year (K – 12) elementary and secondary educational system that will further provide sufficient time for mastery of concepts and skills as well as allow Filipinos to compete in the global market (Government of the Philippines, 2012). Due to the recent implementation of this program, evaluation of the success of the program in terms of knowledge and skills of graduates is limited.

In response to the difference in credentials of internationally educated nurses, the College of Nurses of Ontario partnered with the Centre for the Education of Health Professionals Educated Abroad to create the Internationally Educated Nurses Competency Assessment Program (Centre for the Education of Health Professionals Educated Abroad, 2013). Created in 2013, the Competency Assessment Program assesses internationally educated nurses using an objective structured clinical examination (OSCE) and a multiple choice examination to assess the knowledge, skills and communication abilities of internationally educated nurses before they are provided with a letter of direction by the College of Nurses of Ontario. On completion of the assessment program, the Centre for the Education of Health Professionals Educated Abroad determines if the internationally educated nurse requires additional training for entry into practice as a nurse in Ontario or is ready to take the Canadian Nursing Registration Examination and practice as a nurse in Ontario. While this test represents additional financial and time cost for the internationally educated nurse in Ontario, it serves to ensure that internationally educated nurses demonstrate competence in their knowledge, skill, and judgement before entering the nursing workforce in Canada. Due to the recent implementation of this program, there are currently no data on the effectiveness and fairness of this program.

Access to Bridging Program

In response to the body of research on barriers to workforce integration of internationally educated nurses (Blythe et al., 2009; Jeans et al., 2005; Sochan & Singh, 2007), several bridging and upgrading programs have also been created to reduce the barriers to integration of internationally educated nurses in Ontario. While these programs have had tremendous success in increasing the integration of internationally educated nurses into the health care system in

Ontario, those who migrate through the Live-in Caregiver Program are unable to fully benefit from the program during their 2-year live-in caregiver requirement. This is because live-in caregivers are not permitted to take courses unrelated to their work as live-in caregivers, nor are they allowed to work in the nursing profession during this time. Access to educational programs is more of an issue for live-in caregivers as opposed to other temporary foreign workers due to the program's path to permanent residency; and thus, the long-term goal of integration exists.

In addition, nursing educators identified that during the waiting period between completing the Live-in Caregiver Program and becoming a permanent resident in Canada (which takes one to four years) internationally educated nurses who migrate through the Live-in Caregiver Program must continue to pay international student fees. This fee amounts to the approximate equivalent of the yearly salary of live-in caregivers in Canada. Given this financial cost, educators commented that live-in caregivers will often delay taking bridging programs until after they have become permanent residents in Canada. Similarly, Hawkins' (2013) interviews with nurses who migrated as live-in caregivers found that these migrants experience added barriers to accessing educational programs due to educational policy restrictions and the requirement to pay international student fees. As earlier stated, the College of Nurses of Ontario recently changed its entry into practice requirement by requiring new nurse registrants to demonstrate that they have provided safe nursing practice within the past three years, rather than its earlier policy of within the past five years. This will present more challenges to live-in caregivers who delay registration as they now have a shorter time frame to qualify as a nurse.

A strong point of frustration for several live in caregivers interviewed is the timing of bridging programs. Most bridging and upgrading programs are offered during working hours on weekdays. However, this group of nurses often work weekdays and are only available to attend

such programs on weekends and late evenings. Similarly, the Canadian Association of Schools of Nursing (2012) in their *Pan-Canadian Framework of Guiding Principles and Essential Components for IEN Bridging Programs* identified the need to make bridging programs flexible by offering online and distance educational opportunities. Findings from my thesis further support the need to create bridging programs that are offered in the evenings to accommodate this group of nurses.

OBLIGATIONS OF STAKEHOLDERS

Similar to findings of several other researchers (Cohen, 2000; Pratt, 1997; Spitzer, 2009; Stasiulis & Bakan, 2005), my study found issues of abuse and exploitation of live-in caregivers in Canada. Live-in caregivers are vulnerable to abuse and exploitation due to their legal position in Canada, including their temporary migrant status and the requirement to live in the client's home. One major strategy utilized by live-in caregivers to challenge their negative experience in Canada is to join support and advocacy groups. The role of advocacy groups in ensuring and upholding the rights of live-in caregivers in Canada has been well documented in the literature (Philippine Women Centre, 2001; Stasiulis and Bakan, 2005). Advocacy groups are often created by previous live-in caregivers, with support of individuals within the Filipino community. Such groups, through various political acts, serve to maximize the political power non-citizen live-in caregivers have and challenge the inequities they face in Canada. As Stasiulis and Bakan (2005) discussed, Philippine networks of advocacy groups seek transnational justice and rights through connections and networks around the globe. The networks of advocacy groups challenge the conventional notions of citizenship and the position of live-in caregivers as "modern day servants" in Canada (Stasiulis & Bakan, 2005). Advocacy groups in the province of British

Columbia, especially the Philippine Women Centre, have been very active in demanding the rights of Philippine educated nurses and ending the Live-in Caregiver Program (Philippine Women Centre, 2001).

My study revealed several measures that have been put in place by the Canadian government to protect live-in caregivers, such as mandating an employment contract and requiring employers to pay all recruitment fees related to hiring a live-in caregiver. The implementation of policies to protect live-in caregivers has been mainly the result of pressures from live-in caregiver advocacy groups. However, policies put in place by the government are not always effectively enforced. For instance, of concern to recruiters and live-in caregivers is the lack of a list of reported abusive employers, which the government had promised to release on its website (Canadian Broadcasting Corporation [CBC] November 9, 2012).

Carens (2005) argues that a democratic society has an obligation to protect the rights of those who live within it, including migrant workers. This protection includes ensuring good working conditions for migrant workers and abiding by the law of reciprocal obligations. Concerning reciprocal obligations, as discussed by Carens (2005), what remains opaque is the obligation of stakeholders to skilled Philippine educated nurses who pragmatically use one pathway (i.e., the Live-in Caregiver Program) to enter Canada and then seek to become Registered Nurses. Given that all policy stakeholders are aware that nurses migrate to Canada through the Live-in Caregiver Program and all stakeholders (including the nurses) are aware of the obligations that are required of live-in caregivers, it may seem obvious that the government has no obligation to facilitate the integration of these nurses during the initial two years in Canada, while they complete their Live-in Caregiver Program contract. This argument speaks to

an over-emphasis on the individual agency of nurses who chose to take this migration pathway, and are therefore seen as accountable for the consequences of that decision.

However, utilizing a transnational feminist theoretical perspective in line with Parrenas (2001), it is imperative to consider that “agency is conditioned and therefore limited by the social process from which it emerges and takes place” (p. 34). Similarly, Gardiner-Barber (2008) notes that the agency of migrant Filipina workers is constrained by limited choices. This view emphasizes the need to trace the macro and intermediate global processes and structures that have positioned these women to utilize this route of migration. Driving the extraction of love and care from Philippines to Canada is the commodification and privatization of care due to lack of effective child care (Zaman, 2005) and elder care (Bourgeault et al., 2010) policies in Canada, as well as neo-liberal policies in the Philippines that focus on production for export (Parrenas, 2001; Rodriguez, 2001). My thesis found that the choice by Philippine educated nurses to migrate to Canada as Live-in Caregivers rather than Skilled Workers was influenced by inability to qualify as a skilled worker due to lack of work experience (n=2) and finances (n=4) as well as the long processing time of skilled worker applications. Four live-in caregivers indicated they had insufficient knowledge on the Federal Skilled Worker Program, despite the availability of information on the skilled worker program on the Citizenship and Immigration Canada website.

A more credible reason for the inability to qualify as a skilled worker, including issues of finances, is situated within the tight economic context of the Philippines. Indeed, Hawkins (2013) found that as compared to nurses who migrate to Canada as skilled workers, individuals in her study who choose to migrate through the Live-in Caregiver Program were more likely to have a lower economic status prior to migration. Moreover, driving their choice of migration was the lack of information on the appropriate migration route. Such misinformation is due to the

paucity of knowledge on the part of recruitment agents, family, and friends, about the Live-in Caregiver Program and the process of nursing workforce integration in Canada.

Nurses who migrate from the Philippines to Ontario through the Live-in Caregiver Program have multiple unifying identities, two of which are their identity as a Philippine educated nurse and their identity as a live-in caregiver. Moreover, they occupy two citizenship categories in Canada as both temporary residents and as potential permanent residents in Canada. Given that the Live-in Caregiver Program ensures a path to permanent residency, these workers have a long-term plan in Canada. However, the policies of the Live-in Caregiver Program, including restrictions on taking courses during the program, focuses these workers on the short-term objectives of Canada (to fulfil a perceived labour market shortage) rather than the long-term economic contribution of the workers to the development of Canada as regulated nurses. Similarly, Sager (2009) argues that temporary worker programs are dubious as they treat people as a means (to fulfilling labour market shortages) rather than an end (by ensuring their full integration in potentially transformed roles in Canada). As Canada increasingly shifts to the migration of individuals as temporary foreign workers with later conversion to permanent residents (e.g., through the Canadian Experience Class as described in Chapter 1), this issue of short-term (settlement of temporary foreign workers) versus long-term (integration of permanent resident) goal must be considered.

LIMITATIONS OF THE STUDY

My thesis utilized several quality criteria from qualitative research methodology to strengthen rigour. While measures such as the use of multiple data sources and reflexive engagement were in place to strengthen the trustworthiness of the research findings, there are

limitations. First, my study utilized a sample size of fifteen live-in caregivers and nine policy stakeholders. Although data saturation was reached with my study, consistent with qualitative research methodology in the critical social paradigm, a positivist orientation to sampling may consider such a sample size small. Given the qualitative research methodology, the focus of the utility of my study should be on transferability rather than generalizability of the sample to the live-in caregiver population. Transferability is concerned with the extent to which the research can be applied to other settings, given the context of my study (Shenton, 2004). To ensure the transferability of my study, both descriptive data and quotations from participants have been provided, to allow the reader to evaluate the relevance of the data to other contexts.

Another sampling limitation is the use of snowball sampling for some participant recruitment. Five participants were recruited from an educational service provider and another four participants were friends of these five participants. Snowball sampling is commonly used for hard to recruit participants – such as migrant populations (Cresswell, 2013; Ogilvie, Burgess-Pinto & Caufield, 2008). In my study, one of its benefits is that it revealed the role of networks in shaping participants experience. However, given that snowball sampling relies on the use of networks, there is a chance than the sample may not be representative of the population.

Third, due to the preference of some participants, a number of interviews with live-in caregivers were conducted with someone else in the room. The context ranged from having someone (an observer) present during the interview, to having some sections of an interview as a group discussion, to having someone in the next room. The presence of an observer during the interview may have influenced what live-in caregivers were willing to disclose. While the setting of the interview may not be considered ideal, D'Addario's (2012) interviews of 10 live-in caregivers in Canada also found that live-in caregivers were often reluctant to participate in

research studies due to their fear that it would affect their employment status in Canada and their vulnerability. Similarly, Parrenas (2001) found that the legal and immigration status of domestic workers in Rome contributed to their hesitancy to participate in her study. As with my thesis, to attend to issues of fear related to participation, D'Addario interviewed live-in caregivers in weekend homes and in groups (with other live-in caregivers present at the time of the interview).

Fourth, stakeholders selected for my thesis included immigration policy makers (n=1), representatives of recruiter groups (n=2), nurse educators (n=4), and support groups (n=2). Although the nursing regulatory body in Ontario was invited to participate, they declined. To compensate for this, information on nursing policy in Ontario was gathered through online documents and websites. Also, no employers were involved in my study. The decision not to interview employers was made based on the vulnerability of this group of nurses. The lack of employer and nursing policy insight in my study should be taken into consideration when interpreting the results, which thus largely represents the view of the fifteen live-in caregivers and nine policy stakeholders. Future studies should seek to gain perspective from employers on nurses who migrate to Canada through the Live-in Caregiver Program, especially on issues of exploitation.

IMPLICATIONS OF THE STUDY

My study provides several implications for immigration policy makers, childcare and eldercare policy makers, nursing policy makers (including nurse regulators and nurse educators), and researchers; both locally and globally. While the actions of all these stakeholders has the potential to make a major impact on the experience of internationally educated nurses who enter Canada through the Live-in Caregiver Program, of priority are the implications for immigration

policy makers. It is the very existence of the Live-in Caregiver Program that creates the negative experiences and the barriers to workforce integration for these nurses. In what follows, I will address this group of policy makers first and then articulate the implications of my findings for other stakeholders.

Implications for Immigration and Public Policy

The findings of this research present several implications for Canadian immigration policy makers. First, it must be acknowledged that the government has made several changes in recent years in an attempt to strengthen the Live-in Caregiver Program, including requiring employers to pay all recruitment costs and granting open work permits immediately after program completion (CIC, 2009; 2010). However, several of these policies made in the past have resulted in trade-offs. This speaks to the issues of paradox in policy making as illustrated by Deborah Stone (1988). Policy making involves struggles over values and ideas seen from multiple perspectives. For instance, one recruitment agency identified that the implementation of policies that ensure the employer pays for all live-in caregiver fee, while decreasing financial exploitation of live-in caregivers, has also meant a higher financial burden for employers in Canada without guarantee that the live-in caregiver will remain employed for a significant period of time with the employer.

An important issue with regard to the Live-in Caregiver Program, which has been argued for decades, is if the program should be continued or modified (Bakan and Stasiulis, 1997). In fact, the very existence of the Live-in Caregiver Program creates the added barriers to workforce integration such as the contradictory employer support and the need to attend bridging programs (due to the gap in clinical practice). Live-in caregivers interviewed for my thesis indicated the

program should be modified, while one advocacy group representative indicated that it should be stopped. Both sets of arguments have trade-offs. Supporters for modifying the Live-in Caregiver Program argue that it provides opportunities for women from third world countries to migrate to Canada with their family while opponents of the program argue it represents forms of exploitation of third world women, mainly from the Philippines, who are often skilled (Bakan & Stasiulis, 1997). From the government's perspective, the Live-in Caregiver Program serves to meet economic needs by filling labour market needs due to shortages. However, the immigration policy maker interviewed identified the need to explore if the Live-in Caregiver Program is still meeting the needs it was created to meet, especially given the low retention rate in home care. Of further concern is evidence that indicates the majority of individuals who migrate through the Live-in Caregiver Program are destined to work in the home of family members (Gardiner-Barber, 2008). Citizenship and Immigration Canada is currently worried about these issues, including the legitimacy of contracts and the retention of live-in caregivers. This raises the question of the long-term sustainability of the program. Recently (on October 16, 2013), the Government of Canada announced that it will be making reforms to the Temporary Foreign Worker Program (which includes the Live-in Caregiver Program) "to ensure that Canadians always have the first chance at available jobs" (Governor General of Canada, 2013, p. 6). Given that modifications to the Live-in Caregiver Program may be on the horizon, there is a need for Citizenship and Immigration Canada to ensure the program has a stronger alignment with labour market needs, while ensuring the full protection and integration of live-in caregivers. Also, immigration policy makers should take into account issues of integration of professionals who migrate through this program.

Given that the Live-in Caregiver Program currently exists, several measures can be implemented by immigration policy makers to further strengthen the program. The findings of my thesis parallel those of Cuban (2010) in that internationally educated nurses who migrate as lower skilled care workers are sometimes not adequately informed about their migration choice, especially its consequence for their subsequent nursing workforce integration. Although data from Citizenship and Immigration Canada (see Tables 2, 3, 4) and Kelly et al. (2009) indicate that only a minority of live-in caregivers are nurses, evidence indicates that 79 percent of live-in caregivers have professional qualifications. Policies can be implemented in receiving and destination countries for pre-migration counselling of professionals who are planning to migrate as domestic workers. Skilled professionals (such as nurses) who plan to migrate as domestic workers should receive information about appropriate immigration routes for socio-economic integration in destination countries. Further, clearer information can be posted on the Citizenship and Immigration Canada websites that clarifies expectations after live-in caregivers arrive in Canada.

In 2013, nursing was removed from occupations in demand for the Federal Skilled Worker Program (CIC, 2013d). This may be due to the belief that there is no longer a nursing shortage or demand for nurses in Canada. Despite this, some provinces in Canada have engaged in active recruitment initiatives to hire internationally educated nurses from the Philippines (Globe and Mail, April 8, 2010). This implies that there is a shortage in some areas of Canada. Meanwhile, the International Council of Nurses (2007) condemns the active recruitment of nurses as it often results in the depletion of nurses in areas of great need or, in the case of the Philippines, the need to replace the nurse (Runnel et al., 2007). Creating policies and programs that enable and facilitate the integration of internationally educated nurses who are already in

Canada (especially those who migrate to Canada through the Live-in Caregiver Program) will both address needs of nurses migrating through the Live-in Caregiver Program and address shortage issues in areas of need. For instance, a strategic plan by Citizenship and Immigration Canada on the integration of internationally educated nurses may include further building on the strengths of the CARE for Nurses Program through increased funding support to allow internationally educated nurses who are on open work permit to more fully benefit from the program.

Implications for Global Childcare and Eldercare Policy

Parrenas (2001) and Constable's (2007) study indicates a preference among domestic workers across the globe for the Live-in Caregiver Program, as it provides a path to citizenship which is unavailable for domestic workers in several countries. However, Parrenas (2001) and Stasiulis and Bakan (2005) are highly critical of the program, arguing that live-in caregivers experience "partial citizenship" in Canada. While the strength of the Live-in Caregiver Program should be acknowledged, the notion that migrant domestic workers are partial citizens or non-citizens represents the impact of global capitalism, including global structuring according to gender, race, and class. One strategy to solve this immigration conundrum is to decrease the demand for migrant domestic workers. Carens (2005) argues that the shortage of live-in caregivers exists not because there are not enough domestic workers to do the job but because there are not enough people to do the job for the wages offered. In line with Carens's and Hochschild's (2004) argument, contributing to the demand and exploitation of live-in caregivers is the lack of effective domestic policies to enable families to reconcile the demand of work and reproductive care. The existence of the Live-in Caregiver Program in Canada speaks to the need

for a national child care program and a home care program that meets the needs of individuals requiring longer hours of care.

Implications for Nursing Policy

While the several of the shortcomings of Live-in Caregiver Program can be tackled by immigration policy makers, the findings of my study further presents several implications for nursing policy makers, including global nursing policy makers (particularly in Saudi Arabia and the Philippines), nursing regulatory bodies in Canada, and Canadian nurse educators.

Implications for Global Nursing Policy Makers

There is currently a global shortage of nurses (World Health Organization, 2010) and a shortage of nurses in several specialties and regions in Canada (MacMillan, 2013). Findings from this research demonstrate that Philippine educated nurses come to Canada through the Live-in Caregiver Program to provide informal care (domestic work) in the home while getting paid as a live-in caregiver. Fourteen of the nurses interviewed had transnational nursing experiences as almost all had practised in another country before migrating to Canada. Given the growing transnational migration of nurses, there is a need across the globe for stronger communication across nursing regulatory bodies to facilitate the integration of internationally educated nurses. The difficulty experienced by live-in caregivers who practised in Saudi Arabia in getting the required documentation illustrates the need for a more effective communication between Canadian nursing regulatory bodies and nursing policy makers (including employers) in Saudi Arabia.

There remain several implications for nursing policy makers in key source countries, including the Philippines and countries in the Middle East. As earlier discussed, there are issues with the quality of nursing education programs in the Philippines (Valenzuela & Caoili-Rodriguez, 2008). Accreditation of educational programs in the Philippines is voluntary with a low accreditation rate of 19 percent. Findings from my study illustrate a need to ensure a standard quality assurance program for nursing educational institutions in the Philippines. Based on the findings of Brush and Sochalski (2007), this will necessitate the prioritization of quality of educational programs over the quantity of such programs, including issues of adequate supply of qualified faculty members.

Furthermore, findings illustrate the need to implement effective policies in the Middle East to ensure the retention of internationally educated nurses, especially Philippine educated nurses. In fact, Saudi Arabia has become a “stepping stone” to securing a better working condition and family life in the United States (Ball, 2004) and Canada (Hawkins, 2013). Addressing issues of nurse retention may help in tackling the nursing shortage that is currently experienced in the Middle East, particularly Saudi Arabia (Ball, 2004). Effective policies may involve addressing issues of job satisfaction (Almaiki, Fitzgerald, & Clark, 2012) and the education of children of Philippine educated nurses in the Middle East to maximize retention of internationally educated nurses in this region.

Implications for Canadian Nursing Regulators

There is a strong need for Canadian nursing regulators to create nursing policies that are in agreement with immigration policy and to consider all sources of immigration intakes. For instance, the College of Nurses of Ontario (2012b) recently mandated all new nurse registrants to

demonstrate three years of recent safe nursing practice. This exacerbates a great challenge for live-in caregivers, as it takes three to seven years after they arrive in Canada to become permanent residents and be eligible for registration. Information on the website of Citizenship and Immigration Canada in August 2013 identifies that application processing time is 38 months, in addition to a minimum of 22-month live-in caregiver obligation (CIC, 2013b). The gaps between nursing policy (especially nursing regulatory policies) and immigration policy represent a need for nursing regulators in Canada to consider the global context of migration, and multiple migration pathways, as well as the influences of immigration pathways on the integration of nurses in destination countries. Research is needed in this area to shed light on appropriate time limits for demonstration of safe nursing practice and related educational implications.

Implications for Canadian Nurse Educators

While much has been done recently by nursing education policy makers, including the creation of bridging programs, more can be done in ensuring access to such programs for internationally educated nurses who migrate to Canada through the Live-in Caregiver Program. Nursing educators and nursing education policy makers have a role to play in promoting access to educational programs. In particular, flexible scheduling of bridging programs, including offering programs on evenings and on weekends will further ensure the accessibility of such programs for internationally educated nurses who migrate to Canada as live-in caregivers. This notion is similar to that of the Canadian Association of Schools of Nursing (2012) *Pan-Canadian Framework of Guiding Principles and Essential Components for IEN Bridging Programs*, which advocates for flexible bridging programs, including online programs. Also of importance for issues of access is the issue of the cost of bridging programs. Given that live-in caregivers are

often not able to easily access bridging and upgrading programs due to the prohibitive cost, nursing educators should advocate for allowing individuals at this stage to pay domestic student fees. Policy and funding support are needed from provincial ministries of education to improve access to educational programs during this waiting period.

Implications for Research

Findings from my thesis present several implications for research. Based on a small case study of fifteen Filipina nurses, the findings of my thesis establish the need for further research to explore the deskilling of internationally educated nurses, especially the experience of nurses who are working as lower skilled health and social service workers (including domestic workers) in destination countries. Studies have been undertaken on the deskilling of nurses within the nursing profession (Allan, 2007; O'Brien, 2007), but limited literature exists in nursing on the deskilling of nurses to work as domestic workers in destination countries.

One limitation of my thesis is the small sample size. Also, my thesis looked at only the province of Ontario. Given the increasing inter-relatedness of nursing regulation in Canada, including the implementation of the Labour Mobility Act (Nelson, 2013), comparative research across Canadian provinces on internationally educated nurses (especially those who migrate through the Live-in Caregiver Program) will be useful in shedding light on best practices for integration across Canada. Moreover, there is need for longitudinal research to explore the workforce integration of live-in caregivers, while paying attention to their career path in Canada and the retention of live-in home caregivers. Another limitation of my thesis is the lack of employer perspectives on the Live-in Caregiver Program. There is a need for research to explore the needs of employers of live-in caregivers and to determine if the program is meeting the care

needs of children, the sick, the elderly and the disabled. Given a wide array of research on issues of negative relationship with employers, further research is needed on the relationship between live-in caregivers, employers, and care recipients. Based on this, interventions should be developed to strengthen the relationship.

The focus of my thesis is on the pre-nursing registration stage in Canada. While several studies have been conducted on the experience of internationally educated nurses after becoming registered in Canada, no specific study has been conducted on the experience of internationally educated nurses who have been out of practice for a prolonged period of time (such as live-in caregivers). More research is needed on the integration of internationally educated nurses who have been out of practice for a prolonged period of time.

FINAL CONCLUDING STATEMENT

My study utilized a case study design, qualitative methodology, and the concept of global care chains to shed light on the issue of nurse migration to Canada through the Live-in Caregiver Program. It examined the transfer of domestic work to Philippine educated nurses. The literature has already alluded to the deskilling of nurses as domestic workers in United States (Parrenas, 2001; Tung, 2000), the United Kingdom (Cuban, 2010), and British Columbia (Philippine Women Centre, 2000; Zaman, 2006). While my findings reinforce past research on the migration of live-in caregivers, especially issues of abuse and exploitation (Pratt, 1999; Zaman, 2006), there were several new insights gained from my study. Some of these new insights are motivations for migration that are largely driven by the quest to gain citizenship for the family, a strong emphasis on global social status as perceived by family members in the Philippines, and the role of employers in facilitating or hindering the nursing integration process in Canada.

Based on their motivation for migration (“all for the family”), their view on relationships with employers (“one of the family”), and their creation of familial bonds in weekend homes (creation of “mother” and “daughter” relationship), these experiences are shaped by familial discourses. Moreover, underlying discourses on social position motivate Philippine educated nurses to choose to work in Canada as a domestic worker rather than work as a nurse in other countries. These findings provide several implications for both global and local policies.

There are two sides of the coin to this immigration trend. On one side is the nurse, her individual agency and her pragmatic decision of pathway to migrate. Data from my thesis indicate that such agency is constrained by the forces of globalization and gender based ideologies. On the other side of the coin are the policies in both sending and receiving countries that drive the global care chain, including the production of care for export policies in the Philippines and the commodification of care in destination countries, such as Canada. Given issues of exploitation and deskilling of these workers as well as added barriers to their integration under current policies, immigration, nursing, and health policy makers (in Canada, Philippines, and the Middle East) can implement policies to resolve the complexities in the migration of nurses as live-in caregivers.

Lastly, an important finding is the influence of immigration status on the experiences of these nurses and their subsequent integration into the nursing profession in Ontario and Canada. The Live-in Caregiver Program is the only temporary immigration program that has a definite path to permanent residency. This definite path creates a paradox and contradiction between its short-term goal (to meet labour market shortage by admitting temporary foreign workers to Canada) and the long-term goal of the Canadian permanent resident policy (to ensure the integration of permanent residents). While immigration policy makers emphasize the short-term

goal of meeting labour market shortage of caregivers, live-in caregivers and advocacy groups emphasize the long-term goal of workforce integration. Nursing policy in Ontario and Canada often does not take into consideration the complexities in immigration policy. Therefore, there is a need to bridge nursing and immigration policy gaps to maximize the integration and well-being of nurses who migrate to Canada through the Live-in Caregiver Program.

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TABLES

TABLE 1: DESTINATION PROVINCE OF LIVE-IN CAREGIVERS WHO MIGRATED IN 2009

Province	Number of live-in caregiver
Ontario	6,143
British Columbia	2,662
Alberta	1,996
Quebec	1,392
Manitoba	117
Saskatchewan	82
Nova Scotia	23
New Brunswick	13
North Western Territory	12
Yukon	8
Newfoundland	4
Prince Edward Island	2
Nunavut	0

Adapted from Citizenship and Immigration Canada. (2010). Annual report to Parliament on immigration. Ottawa, Canada: Author. Retrieved March 5, 2011 at http://www.cic.gc.ca/english/pdf/pub/immigration2010_e.pdf

TABLE 2: LIVE-IN CAREGIVER PRINCIPAL APPLICANTS WITH PROFESSIONAL OCCUPATIONS IN HEALTH, 2005-2009*

Occupation	2005	2006	2007	2008	2009
Nurse Supervisors and Registered Nurses	80	73	56	92	83
Therapy and Assessment Professionals	13	12	9	23	12
Other Professional Occupations in Health**	6	4	4	6	11
Total	99	89	69	121	106

* Data for the full year 2009 are preliminary estimates and are subject to change. For 2000-2008, these are updated numbers and different from those of Facts and Figures 2008.

** Other professional occupations in health include pharmacists, dieticians, nutritionists, physicians, dentists, veterinarians, optometrists, chiropractors, and other health diagnosing and treating professionals.

Source: Citizenship & Immigration Canada, RDM, December 2009

Data request tracking number: RE.10.0358

TABLE 3: LIVE-IN CAREGIVER PRINCIPAL APPLICANTS WITH PROFESSIONAL OCCUPATIONS IN HEALTH BY EDUCATION LEVEL, 2005-2009*

Education Level	2005	2006	2007	2008	2009
0-13 years of schooling, trade certificate, and non-university diploma	11	8	7	17	13
Bachelor's, Master's and Doctorate Degree	88	81	62	104	93
Total	99	89	69	121	106

* Data for the full year 2009 are preliminary estimates and are subject to change. For 2000-2008, these are updated numbers and different from those of Facts and Figures 2008. Professional Occupations in Health include Nurse Supervisors and Registered Nurses, Therapy and Assessment Professionals and Other Professional Occupations in Health. Other professional occupations in health include pharmacists, dieticians, nutritionists, physicians, dentists, veterinarians, optometrists, chiropractors, and other health diagnosing and treating professionals.

Source: Citizenship & Immigration Canada, RDM, December 2009

Data request tracking number: RE.10.0358

**TABLE 4 – LIVE-IN CAREGIVER PRINCIPAL APPLICANTS WITH
PROFESSIONAL OCCUPATIONS IN HEALTH BY COUNTRY OF LAST
PERMANENT RESIDENCE, 2005-2009***

Country of Last Permanent Residence	2005	2006	2007	2008	2009
Philippines	96	80	61	104	88
Other countries	3	9	8	17	18
Total	99	89	69	121	106

* Data for the full year 2009 are preliminary estimates and are subject to change. For 2000-2008, these are updated numbers and different from those of Facts and Figures 2008. Professional Occupations in Health include Nurse Supervisors and Registered Nurses, Therapy and Assessment Professionals and Other Professional Occupations in Health. Other professional occupations in health include pharmacists, dieticians, nutritionists, physicians, dentists, veterinarians, optometrists, chiropractors, and other health diagnosing and treating professionals.

Source: Citizenship & Immigration Canada, RDM, December 2009

Data request tracking number: RE.10.0358

APPENDIX A: LIST OF DOCUMENTS ANALYZED

SOURCE	BIBLIOGRAPHY	INFORMATION USED
Citizenship and Immigration Canada (CIC)	Citizenship and Immigration Canada (2009a). News Release: Minister Kenney proposes significant improvement to the Live-in Caregiver Program. Retrieved April 10, 2010 from http://www.cic.gc.ca/english/department/media/releases/2009/2009-12-12.asp	Chapter 6 - News release mandating employers to pay all recruitment costs
CIC	Citizenship and Immigration Canada. (2009d). Speaking points for the Honorable Jason Kenney, P. C., M. P. Minister of Citizenship, Immigration and Multiculturalism at the Kababayan Community Centre to Announce Improvements to the Live-in Caregiver Program. Retrieved September 1, 2013 from http://www.cic.gc.ca/english/department/media/speeches/2009/2009-12-12.asp	Chapter 8 – Evidence that CIC is aware that nurses migrate through the Live-in Caregiver Program
CIC	Citizenship and Immigration Canada. (2011c). Application processing times. Retrieved March 7, 2011 from http://www.cic.gc.ca/english/information/times/index.asp	Chapter 6 - Application processing time for federal skilled workers
CIC	Citizenship and Immigration Canada. (2011a). News Release – Minister Kenney announces important change for live-in caregivers. Retrieved from http://www.cic.gc.ca/english/department/media/releases/2011/2011-12-15.asp	Chapter 7 Part A - Granting of open work permit to live-in caregivers
CIC	Citizenship and Immigration Canada. (2013e). Proof of funds – Federal skilled workers. Retrieved from http://www.cic.gc.ca/english/immigrate/skilled/funds.asp	Chapter 6 - Cost of migrating as a skilled worker
CIC	Citizenship and Immigration Canada. (2013f). Determine your eligibility – live-in caregivers. Retrieved from http://www.cic.gc.ca/english/work/caregiver/apply-who.asp	Chapter 6 - Live-in Caregiver Program Requirement Chapter 8
CIC	Citizenship and Immigration Canada. (2013g). Speaking notes for The Honorable Jason Kenney, P.C., M.P. Minister of Citizenship, Immigration and Multiculturalism. Retrieved from http://www.cic.gc.ca/english/department/media/speeches/2013/2013-03-28.asp	Chapter 8 – Obligations of immigration policy makers
Ontario Ministry of Labour	Government of Ontario. (2000). Employment Standards Act. Retrieved September 1, 2013, from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_00e41_e.htm	Chapter 8 - Rights of live-in caregivers

Ontario Ministry of Labour	Government of Ontario. (2009). Employment Protection for Foreign Nationals Act (Live-in Caregivers and Others). Retrieved from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_09e32_e.htm	Chapter 8 - Rights of live-in caregivers
College of Nurses of Ontario	College of Nurses of Ontario. (2013d). Application and Membership Fees. Retrieved September 2, 2013, from http://www.cno.org/en/become-a-nurse/about-registration/application-membership-fees/	Chapter 7 – Part D Cost associated with nursing registration
Recruiters Website	TLC Edmonton (2013). Employers – Search for Live-in Caregivers. Retrieved from www.tlc-edmonton.com	Chapter 6 - Live-in caregiver advertisement pages
Recruiters Website	CanadianNanny.ca. (2013). How much does it cost. Retrieved from www.canadiannanny.ca	Chapter 6 - Cost of advertisement for recruiters
Canadavisa. Com	www.canadavisa.com Diverse Postings	Chapter 7 Part A Creation of Strike Nannies; Chapter 8 - Use of online discussion forums and recent increase of nurse migrants
Live-in Caregiver Petition Site	Care to Petition Site (2010). Reform Canada’s Live-in Caregiver Program. Retrieved from http://www.thepetitionsite.com/1/reform-canadas-live-in-caregiver-program/	Chapter 7 – Part A. Lobbying by LICs
Petition Site: ACNAC	Association of Caregiver and Nanny Agencies Canada. (2012). Petition Site: Review the Live-in Caregiver Program and Equally Represent/Support the Interest of Families. Retrieved from http://www.thepetitionsite.com/1/review-the-foreign-worker-live-in-caregiver-program-and-equally-represent-and-support-the-interests/	Chapter 8 – Employers’ Perspective on Policy Change Requiring Employers to Pay Fees
CARE for Nurses	CARE (2013). Exam Preparation and Review. Retrieved from http://www.care4nurses.org/what-we-do/exam-preparation/	Chapter 7, Part D- Cost of Nursing Exam Review
Toronto School of Health	Toronto School of Health (n.d). Fees. Retrieved from http://www.torontoschoolofhealth.com/A/Fees.htm	Chapter 7, Part D - Cost of Nursing Exam Review
Toronto School of Nursing	Toronto School of Nursing. (2013). RN Exam Preparation Program Course Review for Canadian Exam. Retrieved from http://www.torontoschoolofnursing.com/CRNE10.php	Chapter 7, Part D - Cost of Nursing Exam Review

APPENDIX B: POSTER AND RECRUITMENT LETTER

FIRST STUDY FLYER

Nurses and Live-in Caregiver Program Study

**Are you an Internationally Educated Nurse from
the Philippines who came to Canada through the
Live-in Caregiver Program?**

We would like to hear from you!!!

We would like to know about the experiences of nurses from the Philippines who came to Canada to work as Live-in Caregivers.

We are interested in hearing from both current nurses in the Live-in Caregiver Program and nurses who have already completed the Live-in Caregiver Program and are either registered as nurses in Canada or NOT registered as nurses in Canada.

To learn more, please contact:

Bukola Salami, RN, MN

PhD Candidate

Lawrence S. Bloomberg Faculty of Nursing

University of Toronto

Supervisor: Dr. Sioban Nelson, RN, PhD

Call: 416-978-1578

Email: bukola.kolawole@utoronto.ca

SECOND STUDY FLYER

STUDY
NURSES AND THE LIVE-IN CAREGIVER
PROGRAM STUDY
SHARE YOUR STORY!

If you are a nurse from the Philippines who came, or is planning to come, to Canada through the Live-In Caregiver Program I want to hear about your experience.

I am a PhD student at the University of Toronto Bloomberg Faculty of Nursing. My research aims to inform policy to assist in the integration of internationally educated nurses in Ontario.

To be eligible to participate in this study, you must:

- 1. Be an internationally educated nurse;**
- 2. Have completed a minimum of 2 years nursing education in the Philippines;**
- 3. Have come to Canada through the Live-in Caregiver Program or currently be in the process of coming to Canada through the Live-in Caregiver Program;**
- 4. Either live in Ontario or have lived in Ontario in the past (if you are already in Canada) AND**
- 5. Speak and understand English language**

Interviews will take place at your convenience. You will receive a small token of appreciate for your time.

To learn more, please contact: Bukola Salami, RN, MN

PhD Candidate

Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

Supervisor: Dr. Sioban Nelson, RN, PhD

Call: 416-978-1578

Email: bukola.kolawole@utoronto.ca

RECRUITMENT LETTER FOR INTERNATIONALLY EDUCATED NURSES

Title: The Migration of Internationally Educated Nurses from the Philippines to Ontario through the Live-in Caregiver Program: A Case Study

Dear Potential Participant,

I am writing to invite you to participate in a study to explore the experiences of internationally educated nurses who came (or are planning to come) to Ontario through the Live-in Caregiver Program. The study is being conducted by Bukola Salami, a doctoral candidate at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, under the supervision of Dr. Sioban Nelson.

Research on internationally educated nurses in Ontario has found that nurses who come to Ontario through the Live-in Caregiver Program face significant barriers to becoming registered to practice. This study seeks to know the experiences of nurses who come to Ontario through the Live-in Caregiver Program. The findings from this study will help inform policy on the integration of internationally educated nurses in Ontario. To be eligible for this study, you must:

- Be an Internationally Educated Nurse.
- Have completed a minimum of 2 years nursing education in the Philippines.
- Have migrated or planning to migrate to Canada through the Live-in Caregiver Program.
- Either be currently living in Ontario or have lived in Ontario in the past. (This criterion does not apply to individuals who have not yet arrived in Canada.).
- Speak and understand English Language

Participation in this study will involve attending an interview session at a time and place that is good for you. The interview will take approximately 1.5 hours and will be audiotaped (i.e. recorded). During the interview, you may be asked to discuss your immigration experience, your experience while in the Live-in Caregiver Program, your experience with the nursing registration process and your views on the responsibilities of policy makers, recruiters, employers and support groups, towards nurses who come to Canada to work as live-in caregivers. You will also be asked to complete a demographical profile form. The form includes information on your age, gender, nursing education, nursing experience, immigration status, and nursing registration status. You will receive a \$20 gift card as a token of appreciation for your time. The information you provide during the study will be kept confidential.

If you are interested in participating or hearing about this study, please contact Bukola Salami at 416 416-978-1578 or bukola.kolawole@utoronto.ca. You are under no obligation to participate in this study. However, your participation will be greatly appreciated. Looking forward to hearing from you.

Thank you

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RECRUITMENT LETTER FOR POLICY STAKEHOLDERS

Title: The Migration of Internationally Educated Nurses from the Philippines to Ontario through the Live-in Caregiver Program: A Case Study

Dear Potential Participant,

I am writing to invite you to participate in a study to explore the diverse perspectives of policy stakeholders on nurses who migrate to Canada through the Live-in Caregiver (LIC) Program. The study is being conducted by Bukola Salami, a doctoral candidate at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, under the supervision of Dr. Sioban Nelson.

Canada is becoming increasingly reliant on temporary foreign workers (including LICs). Scholars and activists have argued that LICs lose several rights. Moreover, researchers have found that nurses who migrate to Ontario through the LIC Program face significant barriers to nursing workforce integration. This study explores the perspectives of diverse policy stakeholders on the issues of rights and obligations of nurses who migrate to Ontario through the LIC Program. The study aims to inform policy on the integration of internationally educated nurses and LICs in Ontario.

You are being approached to participate in this study because you belong to a stakeholder group that can provide insight into the issues of the rights and obligations of nurses who migrate to Canada to work as LICs. If there is someone else in your organization that would be better able to provide insight on this topic, I would appreciate it if you connect me to him or her.

Participation in this study will involve an interview session at a time and place of your convenience. The audiotaped interview will take approximately 45 minutes. During the interview, you will be asked to describe you and your organization's perspective on nurses who migrate to Canada as LICs. You will receive a \$20 gift certificate as a token of appreciation for your time. The information you provide during the study will be kept confidential. You and your organization will not be identified in study reports or presentations and pseudonyms (i.e. fake names) will be used.

If you are interested in participating or hearing more about this study, please contact Bukola Salami at 416 416-978-1578 or bukola.kolawole@utoronto.ca. You are under no obligation to participate in this study. However, your participation will be greatly appreciated. Looking forward to hearing from you.

Thank you

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APPENDIX C: CONSENT FORMS



CONSENT FORM: INTERNATIONALLY EDUCATED NURSES

Title: The Migration of Internationally Educated Nurses from the Philippines to Ontario through the Live-in Caregiver Program: A Case Study

Investigator: Oluwabukola (Bukola) Salami, RN, BScN, MN
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 Telephone: 416 978 2862

Funding Source: Social Science and Humanities Research Council

You are being asked to take part in a study. Before agreeing to participate, it is important that you read and understand this consent form. This form provides the important information you need in order to make an informed decision about whether or not you wish to participate. The following information describes the purpose, procedures, benefits and risks associated with this study. It also describes your right to refuse to participate or withdraw from the study at any time. Should you have any questions, please ask the researcher whose contact information is listed above. Make sure all your questions have been answered to your satisfaction before signing this document.

Purpose and Background

You are being asked to participate in this study because we need to understand the experiences of nurses who come to Canada through the Live-in Caregiver Program. We also need to understand the view of nurses and diverse policy makers on the issue of rights of nurses who come to Canada through the Live-in Caregiver Program and the responsibility of policy makers, employers, recruiters, and support groups to these nurses.

Eligibility Criteria

I understand that I am being approached to participate in this study because I am a nurse who came to Canada through the Live-in Caregiver Program or I am a nurse currently planning on coming to Canada through the Live-in Caregiver Program. In addition, to be eligible for this

study, I have a minimum of 2 years education in nursing earned in the Philippines. Also, I understand that if I am currently in Canada, I must either currently be living in Ontario or have lived in Ontario in the past. Lastly, to be eligible to participate in this study, I must be able to speak and understand English language.

Procedure

Should I agree to participate in this study, I understand that I will attend one interview with the researcher (Bukola Salami). The interview will take approximately 1.5 hours to complete. The interview will take place at a place and time that is good for me. I understand that I will also complete a demographical profile form (including information on my age range, gender, nursing education, nursing experience, immigration status, and nursing registration status).

During the interview, I will be asked to discuss the reasons I came to Canada through the Live-in Caregiver Program, my immigration experience, my nursing registration experience, what I think are my rights as a nurse who came to Canada through the Live-in Caregiver Program, and what are the responsibility of policy makers, recruiters, employers and support groups to me, as a nurse, who came to Canada through the Live-in Caregiver Program. After the first interview, I understand that I may be approached to participate in another interview or given the study preliminary results to read and provide feedback. I have a right to refuse to participate at any stage of the study (including subsequent interviews). The interview(s) will be tape recorded and the researcher (Bukola Salami) may take notes during the interview. All tapes and documents (including the demographic profile) will be kept confidential and anonymous and will only be listened to by the researcher.

Potential Benefits

I understand that there may be no direct benefits from participation in this study. However, this study may provide an outlet for sharing my thoughts on the Live-in Caregiver Program. This study may also provide increased knowledge through self-reflection. Also, the study will lead to a better understanding of the experience and rights of nurses who come to Canada through the Live-in Caregiver Program and policy makers, recruiter, employers and support groups duties to these nurses. This will help to inform policies to improve the integration of this group of nurses into the workforce.

Potential Risks

I understand that there are no direct long or short-term risks anticipated as a result of participating in this study. However, migrating through the Live-in Caregiver Program and going through the registration process, may pose a crisis. Hence, there is a slight possibility that I may experience emotional distress while discussing my experience. If the researcher, an experienced nurse, has any concerns over my response to the interview, a referral will be made to the appropriate health professional or counseling services.

Financial Compensation

I understand that I will receive reimbursement for parking and travel costs associated with participating in the interview. I will also receive an equivalent of \$20 complementary gift certificate or code.

Confidentiality

I understand that the information obtained during the interview will be kept confidential and my identity will not be available to anyone except the researchers. All information obtained in this study will be used for research purpose only. The information obtained during the interview will be kept in a locked and secured area at the University of Toronto and will be destroyed after 7 years. Direct quotes from the interview may be used in reports, presentations and/or publications, but no identifying information will be provided with these quotes. Pseudonyms (i.e., fake names) will be used in research reports or publications. Should I wish the researcher to send me a copy of the preliminary results of the study when it is completed, I should make it known to the study researcher as well as supply my contact information (preferably email address).

Right to Refuse or Withdraw

I understand that my participation is strictly voluntary and I am free to refuse to answer any questions, refuse to take part in the study or to withdraw at any time during the research without risk or penalty.

Contact

I understand that if I have any questions, I can contact Bukola Salami at 416-978-1578 or email bukola.kolawole@utoronto.ca. If I have concerns regarding my rights as a research participant, I can contact the Office of Research Ethics at the University of Toronto at ethics.review@utoronto.ca or 416 946 3273

Consent

My signature on this document indicates that I have read and fully understood the information regarding participation in this study and I agree to participate. In no way does this waive my legal right nor release the investigators, sponsors or involved institutions from their legal or professional responsibilities.

I, _____, the undersigned, agree to participate in the study described. Any questions I had have been answered and I understand what is involved in this study. I realize that my participation in this study is voluntary and there is no guarantee that I will receive any direct benefit from participation in the study. I acknowledge that a copy of this form has been offered to me. I voluntarily consent to participate in this study.

Participant Name (Please Print)

Participant Signature

Date

To be signed by Researcher

To the best of my ability I have fully explained to the participants the nature and purpose of this study. I have provided answers to questions that he or she may have. I believe that this individual fully understands the implications and voluntary nature of the study.

Researcher

Signature

Date

IDENTIFICATION NUMBER _____



CONSENT FORM: STAKEHOLDERS

Title: The Migration of Internationally Educated Nurses from the Philippines to Ontario through the Live-in Caregiver Program: A Case Study

Investigator: Oluwabukola (Bukola) Salami, RN, BScN, MN
 Doctoral Candidate
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Funding Source: Social Science and Humanities Research Council Doctoral Award

You are being asked to take part in a study. Before agreeing to participate, it is important that you read and understand this consent form. This form provides the information you need in order to make an informed decision about whether or not you wish to participate in this study. The following information describes the purpose, procedures, benefits and risks. It also describes your right to refuse to participate or withdraw from the study at any time. Should you have any questions while reading this form or after reading this form, please ask the researcher whose contact information is listed above. Make sure all your questions have been answered to your satisfaction before signing this document.

Purpose and Background

You are being asked to participate in this study because we need to understand the perspective of nurses and diverse stakeholders on the issue of rights of nurses who migrate to Canada through the Live-in Caregiver Program and the obligations of stakeholders to these nurses. I understand that I am being approached to participate in this study because I am a stakeholder (e.g. nursing policy maker, immigration policy maker, recruiter, employer group, advocacy group, or support group) who is involved at a stage in the migration of live-in caregivers or integration of internationally educated nurses in Canada.

Procedure

Should I agree to participate in this study, I understand that I will attend one interview with the researcher (Bukola Salami). The interview will take approximately 45 minutes and will take place at a location and time that is convenient for me.

During the interview, I will be asked to discuss my perspective and those of my organization on the rights of nurses who migrate to Canada through the Live-in Caregiver Program, and the obligations of stakeholders to these nurses. The interview will be tape recorded and notes may be taken during the interview by the researcher. All tapes will be kept confidential and only be listened to by the researcher.

Potential Benefits

I understand that there may be no direct benefits from participation in this study. However, this research will lead to a better understanding of the rights of nurses who migrate to Canada through the Live-in Caregiver Program and stakeholders' duties to these nurses. This will help to inform future policies to improve the integration of this group of nurses into the workforce.

Potential Risks

I understand that there are no direct long or short-term risks anticipated as a result of participating in this study.

Financial Compensation

I understand that I will receive reimbursement for parking and travel costs associated with participating in the interview. I will also receive the equivalent of a complementary \$20 gift certificate.

Confidentiality

I understand that the information obtained during the interview will be kept confidential and will not be available to anyone except the researchers. All information obtained in this study will be used for research purpose only. The information obtained during the interview will be kept in a locked and secured area at the University of Toronto and will be destroyed after 7 years. Direct quotes from the interview may be used in reports, presentations and/or publications, but no identifying information (including my name, my organization's name or my position) will be provided with these quotes. Pseudonyms (i.e. fake names) will be used in research reports or publications. Should I wish the researcher to send me a copy of the results of the study when it is completed, I should make it known to the researcher as well as supply my contact information (preferably, email address).

Right to Refuse or Withdraw

I understand that my participation is strictly voluntary and I am free to refuse to answer any questions, refuse to take part in the study or to withdraw at any time during the research without risk or penalty.

Contact

I understand that if I have any questions, I can contact Bukola Salami at 416-978-1578 or email bukola.kolawole@utoronto.ca. If I have concerns regarding my rights as a research participant, I can contact the Office of Research Ethics at the University of Toronto at ethics.review@utoronto.ca or 416 946 3273

Consent

My signature on this document indicates that I have fully understood the information regarding participation in this study and I agree to participate. In no way does this waive my legal right nor release the investigators, sponsors or involved institutions from their legal or professional responsibilities.

I, _____, the undersigned, agree to participate in the study described. Any questions I had have been answered and I understand what is involved in the study. I realize that my participation in this study is voluntary and there is no guarantee that I will receive any direct benefit from participation in the study. I acknowledge that a copy of this form has been offered to me. I voluntarily consent to participate in this study.

Participant Name (Please Print)

Participant Signature

Date

To be signed by Researcher

To the best of my ability I have fully explained to the participants the nature and purpose of this study. I have provided answers to questions that he or she may have. I believe that this individual fully understands the implications and voluntary nature of the study.

Researcher

Signature

Date

IDENTIFICATION NUMBER _____

APPENDIX D: DEMOGRAPHIC PROFILE QUESTIONS AND DATA



DEMOGRAPHIC PROFILE

Title: The Migration of Internationally Educated Nurses from the Philippines to Ontario through the Live-in Caregiver Program: A Case Study

Identification Number _____ **Date** _____

1. What was your age when you arrived in Canada (or plan to arrive in Canada)?
a) Less than 25 b) 26-35 c) 36-45 d) 46-55 e) 56 and Above
2. What is your gender?
a) Male b) Female
3. What was your marital status when you left the Philippines?
a) Single b) In a Relationship c) Married d) Separated e) Divorced f) Widowed
4. What is your current marital status?
a) Single b) In a Relationship c) Married d) Separated e) Divorced f) Widowed
5. Do you have children?
a) Yes (*How Many and What are their Ages*) _____ b) No
6. What educational qualification(s) did you have pre-migration?
a) Diploma in nursing
b) Bachelor's degree in Nursing (BSN)
c) Masters or graduate degree in Nursing
d) Post graduate nursing certificate or diploma (*please specify*) _____
e) Other training outside nursing (*Please specify*) _____
7. How many years working experience did you have as a nurse prior to migration?
a) Less than 1 year b) 1-2 years c) 3-5 years d) 6-15 years e) Over 15 years
8. What was your nursing specialty pre-migration? _____
9. Have you ever worked in another country outside the Philippines and Canada?
a) Yes (*specify country and job*) _____ b) No
10. What year did you or will you arrive in Canada as a Live-in Caregiver? _____

11. What stage are you currently at in the migration process?
- I have not yet arrived in Canada
 - I am in Canada and I am still completing the live-in caregiver requirement
 - I am in Canada and I have applied for permanent resident status but I **do not** have an open work permit
 - I am in Canada and I have applied for permanent resident status and I have an open work permit
 - I am now a permanent resident in Canada
 - I am now a Canadian citizen
12. Please report all client groups you have provided care for, and duration (i.e. months).
- Elderly_____
 - Children _____
 - Disabled _____
 - Other_____
13. What stage are you currently in the nursing registration process?
- I have not begun the registration process
 - I am currently in the process of registering to become a nurse
 - I began the process of registering to become a nurse but I stopped the process
 - I am currently a Registered Nurse or Registered Practical Nurse in Canada
13. If you answered b or c in Question 12: Have you **written** the Canadian Registered Nurse or Registered Practical Nurse Exam?
- Yes (*Please specify how many times written*)_____ b) No
14. If you answered yes in Question 13: Have you **passed** the Canadian Registered Nurse or Registered Practical Nurse Exam?
- Yes (*Please specify year*) _____ b) No
15. Have you **written** one of the following Language Exam – TOEFL, CELBAN, iBT, MELBAN, IELTS, TOEIC, or TFI (French)?
- Yes (*Please specify how many times written*) _____ b) No
16. If you answered yes in Question 15: Have you **passed** one of the above Language Exam?
- Yes (Specify year)_____ b) No

Thank you for completing the demographic profile

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 Professor and Dean
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 University of Toronto
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DEMOGRAPHIC PROFILE COMPLETE DATA²⁰

	Amy	Bridge t	Cathe rine	Danie lle	Emily	Franc isca	Grace	Hele n	Irene	Jose phine	Krist ine	Leah	Mich elle	Nann ette
Q2	F	F	F	F	F	F	F	F	F	F	F	F	F	F
Q3	Married	Single	Married	Married	Married	Married	Relationship	Single	Single	Married	Married	Married	Married	Separated
Q4	Married	Single	Married	Married	Separated	Married	Relationship	Single	Single	Married	Married	Married	Married	Single
Q7	6-15 yrs	6- 15yrs	15 plus	6-15	3-5	15 plus	6-15	< 1	6-15	<1	15 plus	15 plus	<1	3-5
Q8	Step Down NICU	Neo- nate	Med Surg	Surg- ical	Neph- rology	ER, Gene ral Nurse	Post Anaes thesia Super visor	Psyc h, nursi ng assist ant	Peds, Hem- Onc	No pract ice	PHN , ICU, Peds, Supe rvisor	Comm- unity, Emerg	Emerg	Peds, intern al med, emerg ency, OR
Q9	Saudi	Saudi	Saudi	Saudi	Taiwa n, Libya	Saudi	Saudi	Taiwa n	Saudi, Libya	No	Saudi	Saudi	Saudi	China Taiwa n Germ any
Q10	2009	2009	2008	2009	2006	2006	2007	2011	2005	2007	2009	2001	2006	2005
Q11	Open Work Permit	Open Work Permit	Open Work Permit	Open Work Permit	Perman- ent Reside nt	Open Work Permit	Open Work Permit	Still an LIC	Open Work Permit	Open Work Permit	Open Work Permit	Perman- ent Reside nt	Perman- ent Reside nt	Citize n
Q12	Childr en	Child	Child 3.5 yrs	Disabl ed	Disabl ed	Child 36 mon	Elder, Child, Disabl ed	Child	Elder, Child, Disable	Child	Elderly Child	Elderly , Child, Disable d	Elder , Child	4 elderly, 4 child
Q13	In the Process	in RPN proces s	Not begun	In proces s	RPN	Stopp ed the proces s	In the proces s	Not begun	Not begun	Not begun	In the proc ess	RN	RPN	Stopp ed the Proce ss
Q14 a	NO	NO	No	Yes - 2ce	Yes 2ce	Yes, once	No	No	No	No	No	Yes, once	Yes, 2X	No
Q14 b	NO	N/A	No	No	Yes 2009	No	No	No	No	No	No	Yes, 2004	Yes	No
Q15	Yes – IELTS Once	IELTS	No	No	MELA B Once	No	No	No	No	No	No	MELA B once	MEL AB	No
Q16	Yes, 6 Band Score	YES, 6.5	No	No	2010	No	No	No	No	No	No	Yes, 2003	Yes, MEL AB	No

²⁰ Participant's age (Question 1) and children's age (Question 5) has been removed from the table to increase anonymity. Age ranged from 23 to 25 years. Children's age ranged from 2 years to 32 years. Education (Question 6) has been eliminated. All had a baccalaureate degree in nursing. In addition, Nannette had a Bachelor of Commerce and Bachelor of Midwifery. Olivia's information is not included in the demographic profile as she participated in the pilot study and did not complete a demographic profile.

DEMOGRAPHIC DATA SUMMARY

	Country of Work Experience outside Philippines	Immigration Status	Nursing Registration Status
Nurse 1 – Amy	Saudi	Open Work Permit	In the process
Nurse 2 – Bridget	Saudi	Open Work Permit	In the process
Nurse 3 – Catherine	Saudi	Open Work Permit	Has not begun the process
Nurse 4 – Danielle	Saudi	Open Work Permit	In the process
Nurse 5 – Emily	Taiwan, Libya	Permanent Resident	RPN
Nurse 6 – Francisca	Saudi	Open Work Permit	Stopped the process
Nurse 7 – Grace	Saudi	Open Work Permit	In the process
Nurse 8 – Helen	Taiwan	Still LIC	Has not begun the process
Nurse 9 – Irene	Saudi, Libya	Open Work Permit	Has not begun the process
Nurse 10 – Josephine	None	Open Work Permit	Has not begun the process
Nurse 11 – Kristine	Saudi	Open Work Permit	In the process
Nurse 12 – Leah	Saudi	Permanent Resident	RN
Nurse 13 – Michelle	Saudi	Permanent Resident	RPN
Nurse 14 – Nannette	China, Taiwan and Germany	Citizen	Stopped the process
Nurse 15 – Olivia	Saudi	Live-in caregiver	In the process

APPENDIX E: INTERVIEW QUESTIONS

INTERVIEW QUESTIONS FOR CURRENT LIVE-IN CAREGIVERS

- Tell me about how you came to Canada
- What made you choose to come to Canada through the Live-in Caregiver Program rather than another immigration program?
 - Did you consider coming to Canada through another immigration stream? Why or why not?
 - Probe for sufficient finances and nursing experience
- What resources did you use during the migration process?
 - What information did you have prior to migration?
 - Who or where did you get information from?
 - Probe: Government representatives, nursing regulatory bodies, recruiters, friends, family members, employers, internet
 - Did you use recruiters? What was your experience with recruiters?
 - Do you now feel you had enough information on live-in caregivers in Canada prior to migration?
- How does your family feel about your migration?
 - Probe: Partner's feelings, Children's feelings, Parent's feelings
 - Probe: Do you have children? Who is taking care of them? How do they feel about your migration?
 - What are your current thoughts about living apart from your family?
- What has been your experience since you arrived in Canada to work as a live-in caregiver?
 - What are the advantage and disadvantages (if any) of being a live-in caregiver?
 - What do you think about the type of work you do in your employer's home?
 - What do you think about living in someone else's home?
 - What do you think about having to work as a live-in caregiver for two years before you can become a permanent resident or a nurse in Canada?
- What do you plan to do after you complete the Live-in Caregiver Program?
 - Do you plan to become a nurse after you complete the program?
 - If no: What is your career or financial plan?
 - Why do you plan not to become a nurse in Canada?
 - If yes: What have you done to help you become a nurse in Canada?
 - Probe: Have you completed the language examination and nursing licensing examination?
 - What do you plan to do in the future to help you become a nurse in Canada?
 - Who or where are you currently receiving help from?
 - Who or where do you hope to receive help from (in the future)?
- Is there anyone, group, or organization that you hope you would have received help from but you did not get help from?

- What kind of help did you need and did not get?
- Do you think the Canadian society has a responsibility to nurses who migrate to Canada through the Live-in Caregiver Program? Please explain?
 - Are there any policy or stakeholder groups (i.e. policy makers, recruiters, employer and support groups) that you think should be doing more to assist and integrate nurses who migrate to Canada through the Live-in Caregiver Program? Please explain.

INTERVIEW QUESTIONS FOR PREVIOUS LIVE-IN CAREGIVERS

- Tell me about how you came to Canada
- What made you to choose to come to Canada through the Live-in Caregiver Program rather than another immigration program?
 - Did you consider coming to Canada through another immigration stream? Why or why not?
 - Probe for sufficient finances and nursing experience
- What resources did you use during the migration process?
 - What information did you have prior to migration?
 - Who or where did you get information from?
 - Probe: Government representatives, nursing regulatory bodies, recruiters, friends, family members, employers, internet
 - Did you use recruiters? What was your experience with recruiters?
 - Do you now feel you had enough information on live-in caregivers in Canada prior to migration?
- Are your family members currently in Canada?
 - If no: How does your family feel about your migration?
 - Probe: Partner's feelings, children's feelings, parent's feelings
 - Probe: Do you have children? Who is taking care of them? How do they feel about your migration?
 - What are your thoughts about leaving your family behind in the Philippines?
 - If yes: How does your family currently feel about living apart from you for some years, but now living with you in Canada? Was the period of separation worth it?
- What has been your experience since you arrived in Canada to work as a caregiver?
 - If any, what were the advantages and disadvantages of being a caregiver?
 - What do you think about the type of work you did in the home?
 - What did you think about living in someone else's home?
 - What did you think about having to work as a live-in caregiver for two years before you could become a permanent resident or become a nurse?
- What was your employment experience after the Live-in Caregiver Program?
 - Are you currently a nurse in Canada?
 - If yes: What did you do to become a nurse in Canada?
 - ❖ Probe: Language examination, Canadian Registered Nurses Examination, bridging programs
 - If no: Do you plan to become a nurse in the future?
 - If no: What is your career or financial plan? Why did you plan not to become a nurse in Canada?
 - If yes: What has been your experience in trying to become a nurse in Canada?

- ❖ What have you done to help you become a nurse in Canada?
 - a. Probe: Language examination, registered nursing examination, bridging programs.
 - ❖ What do you plan to do in the future to help you become a nurse in Canada?
 - ❖ Who or where are you receiving help from?
- Is there anyone, group, or organization that you hope you would have received help from but you did not get help from? What kind of help was it?
 - Do you think the Canadian society has a responsibility to nurses who migrate to Canada through the Live-in Caregiver Program? Please explain?
 - Are there any policy or stakeholder groups (i.e. policy makers, recruiters, employer and support groups) that you think should be doing more to assist and integrate nurses who migrate to Canada through the Live-in Caregiver Program? Please explain.

INTERVIEW QUESTIONS FOR RECRUITERS

- How do you recruit live-in caregivers?
 - Where do you advertise to recruit live-in caregivers?
 - What skills do you look for in choosing who you want to recruit?
 - How do you help potential live-in caregivers in the migration process?
 - What information do you provide to potential live-in caregivers prior to migration?
 - Do you refer them to any other resources? If yes, what resources do you refer them to?

- If you recruit or have recruited nurses in the past to work as live-in caregivers:
 - Where do you recruit them from?
 - How do you recruit them?
 - Do you give preference or considerations to nurses or those with health care background when you are choosing who to recruit?
 - If yes, what are these considerations?
 - Do you provide any help or information to them about becoming a nurse in Canada pre-migration? What were this help or this information?

- What has been your experience with these nurses once they are in Canada?
 - Do you provide any kind of settlement support for these nurses once they arrive in Canada? If yes, what kind of support?
 - Do you provide any support to these nurses in becoming licensed to practice as a nurse in Canada?
 - If yes: what kind of support do you provide?

- What are your views on nurses who migrate to Canada to work as live-in caregivers?
 - If any: What do you think are the advantages and disadvantages of this choice?

- What is your role or your organization's role in settlement and integration of nurses who migrate as live-in caregivers?
 - What do you think recruiters or your organization should do (or should not do) to help nurses who migrate to Canada through the Live-in Caregiver Program?

- What do you think should be the role or duty of other stakeholder groups towards nurses who migrate to Canada as live-in caregivers?
 - Probe: Citizenship and Immigration Canada, Human Resource and Skills Development Canada, Philippine Government, nursing professional bodies, employers, support or advocacy groups, and live-in caregivers

**INTERVIEW QUESTIONS FOR SUPPORT AND ADVOCACY GROUPS (INCLUDING
NURSING EDUCATORS)**

- What is your experience with live-in caregivers?
 - What kind of need do live-in caregivers who come to your organization often require?
 - What kind of support does your organization provide to live-in caregivers?

- What is your experience with nurses who migrate to Canada through the Live-in Caregiver Program?
 - Does your organization provide any kind of support with the nursing registration process?
 - If yes: What kind of support does your organization provide to nurses who migrate to Canada through the Live-in Caregiver Program to help them in becoming nurses in Canada?

- What are your views on nurses who migrate to Canada to work as live-in caregivers?
 - What do you think are the advantages and disadvantages of this choice?

- What is your role or your organization's role in the settlement and integration of nurses who migrate as live-in caregivers?
 - What do you think support groups or your organization should do (or not do) to help nurses who migrate to Canada through the Live-in Caregiver Program?

- What do you think should be the role or duty of other stakeholder groups towards nurses who migrate to Canada as live-in caregivers?
 - Probe: Citizenship and Immigration Canada, Human Resource and Skills Development Canada, Philippine Government, nursing professional bodies, employers, recruiters, and live-in caregivers

INTERVIEW QUESTIONS FOR POLICY MAKERS (NURSING AND IMMIGRATION)

- What role does your organization play in the migration and/or registration process of nurses who migrate to Canada through the Live-in Caregiver Program?
- Are there any recently released policies or policies currently in process of being developed by your organization that relates to internationally educated nurses or live-in caregivers?
 - What are these policies?
 - How does it help or not help internationally educated nurses or live-in caregivers?
- What kind of policies, support or resources does your organization have in place to help or protect internationally educated nurses or live-in caregivers?
- What are your views or the views of your organization on nurses who migrated to Canada to work as live-in caregivers?
 - What do you think are the advantages and disadvantages of this choice?
- What is the role of your organization in the settlement and integration of nurses who migrate to Canada to work as domestic workers?
 - What do you think policy makers or your organization should do (or not do) to help nurses who migrate to Canada through the Live-in Caregiver Program?
- What do you think should be the role or duty of other stakeholder groups towards nurses who migrate to Canada as live-in caregivers?
 - Probe: Citizenship and Immigration Canada, Human Resource and Skills Development Canada, Philippine Government, nursing professional bodies, employers, recruiters, support or advocacy groups, and live-in caregivers

APPENDIX F: RESEARCH REPORT

RESEARCH REPORT
EMAIL TO PARTICIPANTS

Dear Participant,

Thank you for participating in the research study: A Case Study on The Migration of Philippine educated nurses to Ontario through the Live-in Caregiver Program. Your participation was vital to the success of the research as it provided much needed insight into the experience of nurses who migrate to Ontario through the Live-in Caregiver Program and the diverse obligations of stakeholders towards their integration.

Please find attached a brief research report for the study. A full report will be available on the University of Toronto T-Space in mid to late 2014. Please feel free to contact me if you have any comments or questions.

Thank you,

Bukola Salami, RN, MN

PhD Candidate

Lawrence S. Bloomberg Faculty of Nursing

University of Toronto

**All for the Family: A Case Study on the Migration of Philippine Educated Nurses to
Ontario through the Live-in Caregiver Program**

Research Report to Participants

Background

The Live-in Caregiver Program is a migration stream that allows individuals to migrate temporarily to Canada to provide care to children, the elderly, and the disabled, while living in the client's home. Live-in caregivers qualify for permanent resident status after a minimum of 22 months and a maximum of 4 years. Evidence suggests that nurses migrate to Canada through the Live-in Caregiver Program (Kelly et al., 2009; Philippine Women Centre, 2000; Pratt, 1999). Researchers in the province of British Columbia found that nurses who migrate to that province through the Live-in Caregiver Program experience abuse and barriers in access to the nursing profession (Philippine Women Centre, 2000; Pratt, 1999; Zaman, 2006). Prior to the conceptualization of this study, no research had been done on nurses who migrate to Ontario through the Live-in Caregiver Program. Moreover, no research has explored the diverse perspective of policy stakeholders on the Live-in Caregiver Program.

Theoretical Framework and Methodology

The research study utilized the transnational feminist concept of global care chain (Hochschild, 2004) and a single case study methodology (Yin, 2009). Participants interviewed for this study included fifteen baccalaureate prepared nurses who migrated to Ontario through the Live-in Caregiver Program and nine policy stakeholders. Policy stakeholders interviewed for this study included one immigration policy maker, two representatives of recruiter groups, two representatives of support/advocacy groups, and four nurse educators.

Results

The results of the study illustrate a two-step migration pattern. Fourteen of the participants interviewed for this study had work experience outside the Philippines prior to migration to Canada. The predominant country of residence prior to migration to Canada was Saudi Arabia (11 participants had work experience in this country). The motivation for emigration from the Philippines was mainly for economic gain. The motivation for migration from the Middle East (often the location of last residence) was to gain citizenship for the family. While most of these care workers could have migrated as permanent residents to Canada, they chose the live-in caregiver immigration route because of lack of knowledge on the added challenges they would face as a nurse who migrated to Canada through the Live-in Caregiver Program, lack of adequate finances to qualify for the skilled worker program, and the longer processing time of skilled worker applications; one participant did not qualify due to inadequate nursing experience. The nurses interviewed for this study expected that they would become a permanent resident and a nurse after the completion of the Live-in Caregiver Program.

On migration to Canada, live-in caregiver participants experienced exploitation. Almost all participants were not paid for all wages worked and those who were paid for wages worked were not paid overtime (1.5 times the pay according to Canadian policy). The experience of exploitation was complicated by their immigration status in Canada and the requirement to live in the client's home. Four participants described their experience of abuse by the employer and threats of jeopardizing their migration in Canada. Other participants described feeling like a "servant" due to their downward occupational mobility in Canada. Their challenges were further complicated by the absence of their family in Canada. Live-in caregiver participants further commented on the pain of family separation. To emphasize the humane aspect of their lives,

especially in the absence of family members in Canada, some live-in caregivers liked to be treated by employers like a family. However, live-in caregivers who experienced abuse in the past emphasized that employers used the sentiment of being treated like a family to further exploit them. One participant clarified this contradiction noting that her preference to be treated like a family or an employer depended on the respect she received from her employers.

To become a nurse in Canada, live-in caregivers must complete the registration process with the College of Nurses of Ontario. At the time of this study, the College of Nurses of Ontario required all nurses to demonstrate five years of recent safe nursing practice to qualify as a nurse in Ontario. Due to the length of time in completing the Live-in Caregiver Program and subsequently gaining permanent resident status, live-in caregivers are often required to take bridging and upgrading programs. Live-in caregivers commented on the barriers in taking educational programs, including the restrictions on taking courses while working as a live-in caregiver, the cost of taking educational programs (including the requirement to pay international fees), and the lack of availability of educational programs on evenings and weekends. Educators of live-in caregivers corroborated issues of cost of taking bridging programs at the college and university level, especially given the financial demand live-in caregivers face in sponsoring their dependents. Further complicating their nursing integration experience is the barrier they face in credential assessment. Consistently, participants described the barriers in getting documents that are required by the College of Nurses of Ontario from Saudi Arabia, especially after five years of not working for a specific institution. Also, participants identified that despite equal years of nursing education, nurses who graduate from specific institutions in the Philippines, especially those who graduate from colleges, are often only allowed to register as Registered Practical Nurses in Ontario. While most live-in caregivers interviewed were unaware of the pending

changes to entry into practice, which would require them to demonstrate safe nursing practice within three years prior to registration, three of the educators interviewed had utmost concern about this policy change as they identified that it will create further barriers to the integration of this group of nurses.

Live-in caregivers and stakeholders were asked about the obligations of diverse stakeholders. Recruiters and the immigration policy maker interviewed identified that the obligations of live-in caregivers is mainly to work as a live-in caregiver for a minimum of 22 months and to comply with the rules of the Live-in Caregiver Program. Live-in caregivers and support groups also identified that the obligation of employers includes complying with the Live-in Caregiver Program policy and contract (just like live-in caregivers) and not abusing or exploiting live-in caregivers. Live-in caregivers, support groups, and some nurse educators identified that recruiters should provide adequate information to live-in caregivers prior to migrating to Canada. Some live-in caregivers interviewed further identified the role recruiters play in connecting them to vital networks in Canada. Educators of live-in caregivers emphasized their obligation to ensure internationally educated nurses demonstrate accountability in nursing practice as well as their obligation to support internationally educated nurses in their integration. Live-in caregivers emphasize that nursing policy makers can do more by removing barriers to registration such as recognizing their education as equivalent to that of a Registered Nurse. The most emphasized obligation by live-in caregivers and policy stakeholders interviewed is that of immigration policy makers to ensure faster processing of live-in caregiver permanent resident applications.

In conclusion, the findings of the study reveals that familial obligations (to gain citizenship for the family), influence the migration decision of nurses who migrate to Ontario

through the Live-in Caregiver Program. The gaps between immigration policy and nursing policy complicate the workforce integration of this group of nurses.

Limitations:

Despite several measures to strengthen the quality of this study small sample size as well as the lack of perspective of nursing policy makers in Canada, employers, and nursing policy makers in source countries (including the Philippines and the Middle East) must be taken into consideration.

Implications

The results of this study present several implications for policy stakeholders (including immigration and nursing policy makers) in easing the integration of this group of nurses in Canada. The integration of nurses who migrate to Canada through the Live-in Caregiver Program can be enhanced by immigration policy makers through:

- Faster processing of live-in caregiver application
- Adequate pre-migration information for professionals who plan to migrate to Canada through the Live-in Caregiver Program
- Further protection of the rights of live-in caregivers

Implications for nursing policy stakeholder include:

- Stronger alignment between immigration and nursing policy
- Creation of evening and weekend programs for internationally educated nurses
- Stronger communication among nursing regulatory bodies across the globe to facilitate the integration of internationally educated nurses