Canada’s (Live-in) Caregiver Program: Perceived Impacts on Health and Access to Health Care among Immigrant Filipina Live-in Caregivers in the Greater Toronto Area, Ontario, Canada

by

Jessica Krystle Carlos

A thesis submitted in conformity with the requirements for the degree of Master of Arts
Graduate Department of Geography
University of Toronto

© Copyright by Jessica Krystle Carlos (2016)
Canada's (Live-in) Caregiver Program: Perceived Impacts on Health and Access to Health Care among Immigrant Filipina Live-in Caregivers in the Greater Toronto Area, Ontario, Canada

Jessica Krystle Carlos

Master of Arts

Graduate Department of Geography
University of Toronto
2016

Abstract

This research examines the relationship between employment as a live-in caregiver under the (Live-in) Caregiver Program and health and access to health care services in the Greater Toronto Area, Ontario. Semi-structured interviews are used to examine how perceptions of health and access to health care services are impacted by employment conditions among twenty-one current and former immigrant Filipina live-in caregivers. The findings demonstrate that employment as a live-in caregiver negatively impacts physical health due to a change in diet, increasingly sedentary lifestyle and exposure to a negative environment. Negative impacts on mental health was also reported due to family separation and work related stress. Further, being a live-in caregiver was seen to facilitate and create barriers accessing health services. Future research must examine more socially isolated caregivers as well as caregivers living-out(side) their place of employment to examine the impact other aspects of employment as a caregiver has on health.
Acknowledgments

There are a number of individuals I would like to for their contribution to this research.

First, I would like to thank my supervisor, Kathi Wilson. I have learned so much under your supervision and would not be where I am today without your encouragement, support, guidance and feedback. I would also like to thank Rachel Silvey. Thank you for your inspiration and support throughout the research process. Additionally, I would like to acknowledge all the participants who took the time to share their stories with me. A special thanks goes to members of my family (Iluminada Lopez-Carlos, Jesus Carlos and Joshua Carlos) for their unconditional love, constant motivation and care. Finally, I would like to show my appreciation to David Bailey and Savvy for their patience and enthusiasm.
# Table of Contents

Abstract............................................................................................................................................. ii  
Acknowledgments............................................................................................................................. iii  
Table of Contents............................................................................................................................... iv  
List of Tables ....................................................................................................................................... vii  
List of Figures ....................................................................................................................................... viii  
List of Appendices ............................................................................................................................... ix  
Chapter 1 .............................................................................................................................................. 1  
1 Introduction ....................................................................................................................................... 1  
   1.1 Thesis Outline ........................................................................................................................... 6  
Chapter 2 .............................................................................................................................................. 8  
2 Literature Review ............................................................................................................................. 8  
   2.1 Introduction ............................................................................................................................... 8  
   2.2 Immigration and Health .......................................................................................................... 12  
   2.3 Temporary Migration and Health ............................................................................................ 22  
   2.4 Filipina Caregivers and Health: Global Perspective .............................................................. 24  
   2.5 Filipina Caregivers in Canada ................................................................................................. 27  
   2.6 Conclusion ............................................................................................................................... 31  
Chapter 3 .............................................................................................................................................. 33  
3 Research Methods ........................................................................................................................... 33  
   3.1 Introduction ............................................................................................................................. 33  
   3.2 Qualitative Research Approaches .......................................................................................... 33  
   3.3 Recruitment, Participants and Data Collection ........................................................................ 36  
   3.4 Data Analysis ............................................................................................................................ 44  
   3.5 Ensuring Rigour in Qualitative Research ............................................................................... 44  
   3.6 Conclusion ............................................................................................................................... 46
Chapter 4........................................................................................................................................47
  4 Results .........................................................................................................................................47
    4.1 Introduction ..........................................................................................................................47
    4.2 Migration Expectations .........................................................................................................47
      4.2.1 Why Canada ..................................................................................................................48
    4.3 Employment Expectations .....................................................................................................50
    4.4 Employment Realities ...........................................................................................................52
      4.4.1 Working Overtime .........................................................................................................52
      4.4.2 Working Outside the Contract ......................................................................................54
      4.4.3 Privacy ..........................................................................................................................55
      4.4.4 Freedom .........................................................................................................................57
    4.5 Health Status of Immigrant Filipina Caregivers .................................................................58
      4.5.1 Overall Health and Changes and Maintenance of Health Status ..................................59
      4.5.2 Employment and Health ..............................................................................................60
      4.5.3 Social Support and Health ............................................................................................63
    4.6 Accessibility to Health Care Services ....................................................................................64
    4.7 Summary ...............................................................................................................................67
Chapter 5 – Discussion, Recommendations and Conclusions ..................................................69
  5 Discussion, Recommendations and Conclusion ....................................................................69
    5.1 Summary of Key Findings .....................................................................................................69
    5.2 Limitations and Areas of Future Research ..........................................................................70
    5.3 Theoretical Contributions ..................................................................................................71
      5.3.1 Immigration and Health ...............................................................................................72
      5.3.2 Employment as a Temporary Foreign Worker and Health ..........................................74
      5.3.3 Immigrant Filipina Live-in Caregivers in Canada .........................................................76
    5.4 Policy Recommendations ....................................................................................................76
5.5 Conclusion .................................................................................................................. 79
References......................................................................................................................... 80
Appendices......................................................................................................................... 89
List of Tables

1. Temporary Foreign Worker Program Permit Holders by Program, 2005-2014 .............11
2. Characteristics of Research Participants.................................................................42
List of Figures

1. Permanent Residents by Immigration Category, 1996-2014.............................................10
2. Recruitment Poster at the Metropolitan Bible Baptist Church ...........................................37
3. Recruitment Poster advertised in the April 8-21 issue of the Philippine Reporter...........38
List of Appendices

1. Appendix 1: Letter of Information ................................................................. 89
2. Appendix 2: Consent Form ........................................................................... 91
3. Appendix 3: Interview Script ....................................................................... 92
4. Appendix 4: Demographic Survey ................................................................. 96
5. Appendix 5: Recruitment Poster ................................................................. 97
Chapter 1

I Introduction

In Canada, the immigrant population accounts for approximately 20 percent of the total population with approximately 250,000 individuals immigrating to Canada each year (Statistics Canada, 2015a). The number of immigrants residing in Canada has increased from 5.4 million individuals in 2001 to approximately 6.8 million immigrants as of 2011 (Statistics Canada, 2015a). As the number of migrants immigrating to Canada continues to increase, Statistics Canada (2016) predicts that more than 80 percent of Canada’s population growth will rely on immigration by 2031.

Prior to the 1970s, only citizens from the United States, the United Kingdom, Ireland, New Zealand, South Africa and other Northwestern European countries were permitted to immigrate to Canada (Anwar, 2014). In 1967, changes to Canada’s immigration policy, the Immigration Act, shifted towards accepting immigrants based on education and occupational skills to fill labour shortages rather than by country of origin (Anwar, 2014; Borjas, 1993). Canada now has four broad categories under which immigrants can be accepted: economic class, family class, refugees and other. As of 2014, 165,089 immigrated under the economic class, 66,661 immigrated under the family class, 23,286 arrived as refugees and 5,357 came to Canada under the ‘other’ category (CIC, 2015a). While the economic class constitutes more recent programs (e.g., Live-in Caregiver Program), foreign temporary workers have a long history in Canada.

The recruitment of domestic workers outside of Canada has occurred for centuries. During the second half of the nineteenth century, a rise in the urban middle-class as well as an increasing success among farmers in rural areas was observed in Canada (Cohen, 2000). As a
result, domestic work became a necessity and a status symbol (Cohen, 2000). Women from the British Isles were encouraged by the Canadian government to immigrate to Canada to populate by starting a family and finding employment as domestic workers (Barber, 1991). Some women of the British Isles were provided with financial assistance to immigrate to Canada (Barber, 1991). Eighty percent of the domestic workers who immigrated to Canada were from the British Isles between the turn of the century until World War I (Cohen, 2000). During the Great Depression and World War II, the admittance of domestic workers temporarily stopped (Cohen, 2000). However, after World War II, the demand for domestic workers grew as British and Western European women left the field of domestic work due to factors such as long hours, isolation, denial of privacy and a lack of respect (Macklin, 1992). The labour shortage of domestic workers led British Caribbean governments to lobby the Canadian government to allow large numbers of Caribbean domestic workers to enter Canada (Macklin, 1992). In 1965, approximately 1,500 West Indian individuals immigrated to Canada as domestic workers (Macklin, 1992).

With the implementation of the Immigration Act in 1967, which favoured the acceptance of highly skilled individuals, immigrants qualifying for a job considered to be of low skill, such as domestic work, found it difficult to permanently immigrate to Canada (Cohen, 2000). As a result, in 1973, the Canadian federal government introduced the Temporary Employment Authorization Program (Bakan & Stasiulis, 1997). Domestic workers were given temporary short-term work permits as opposed to being provided with an opportunity to be eligible for permanent status (Bakan and Stasiulis, 1997). Prior to the change in policy in 1973, domestic workers were granted permanent residents status upon arrival (Bakan and Stasiulis, 1997). The introduction of the Temporary Employment Authorization Program in 1973 led to the distribution of short-term work permits among foreign domestic workers where workers were to
return to their country of origin upon completion of their work permit (Bakan and Stasiulis, 1997; Boyd, Taylor & Delaney, 1986) To remain in Canada, foreign domestic workers were required to have an employer (Bakan and Stasiulis, 1997; Macklin, 1992).

In 1981, the Foreign Domestic Movement replaced the Temporary Employment Authorization Program (Macklin, 1992). To immigrate to Canada under the Foreign Domestic Movement, individuals were required to have a Canadian Grade 12 equivalent education and six months of full-time training as a domestic worker (Macklin, 1992). To apply for permanent residency under the Foreign Domestic Movement, individuals had to be employed as a domestic worker for two years and live in their place of employment (Bakan and Stasiulis, 1997). Prior to the introduction of the Foreign Domestic Movement in 1981, domestic workers were not required to live in their place of employment (Bakan and Stasiulis, 1997). In addition to the new live-in condition, domestic workers were required to demonstrate that they had upgraded their occupational skill by going to school and demonstrate that they could integrate into the Canadian society by being involved in volunteer work (Bakan & Stasiulis, 1997). The upgrading and social integration requirements were removed in 1992 under the new Live-in Caregiver Program after domestic workers and their advocates successfully convinced the Canadian government that the requirements were unfair given that such requirements were not used to assess the eligibility of permanent residency among other immigrants (Bakan & Stasiulis, 1997). However, higher levels of education and training were introduced in the Live-in Caregiver Program. For individuals to be eligible for permanent residency under the Live-in Caregiver Program, individuals must complete the following requirements:

i. “A positive Labour Market Impact Assessment (LMIA) from an employer in Canada

ii. A written contract with [the] future employer, signed by [employee] and the employer

iii. Successful completion of the equivalent of a Canadian secondary school education
iv. At least six months training or at least one year of full-time paid work experience as a caregiver or in a related field or occupation (including six months with one employer) in the past three years
v. Good knowledge of English or French

A Labour Market Impact Assessment is a document completed by an employer requiring a caregiver that demonstrates the need for a foreign worker in Canada. The assessment must demonstrate that no Canadian worker can fulfill the job. The Labour Market Impact Assessment includes the employer and worker’s personal information, information regarding the job offer, proof of an attempt to recruit workers within Canada (e.g., advertisements) and a list of 23 statements for employers to check to certify that they will comply with the rules and regulations of the Labour Market Impact Assessment.

In November 2014, a final change was made to the Live-in Caregiver program resulting in the creation of the Caregiver Program. The main change was the removal of the live-in requirement as it was seen to lead to abuse and family separation (Government of Canada, 2014). The Caregiver Program also included two new pathways to permanent residency: i) Caring for Children Pathway; and ii) Caring for People with High Medical Needs Pathway. Changes from the Live-in Caregiver Program also included an increase in the educational requirement (from Canadian secondary education to at least one year of Canadian post-secondary education equivalent) and the completion of a language test administered by Citizenship and Immigration Canada (CIC, 2014).

Changes to immigration policies over the years have facilitated the movement of domestic workers from various parts of the world. As previously mentioned, the majority of foreign domestic workers were recruited from the British Isles in the mid-to-late nineteenth century (Barber, 1991). Women originating from third world countries, such as Jamaica and
Barbados, began immigrating to Canada as foreign domestic workers in the 1950s (Bakan and Stasiulis, 1997; Cohen, 2000). In the 1980s, foreign domestic workers originated from Europe, the Caribbean, the United Kingdom, and the Philippines (Macklin, 1992). In 1992, introduction of the Live-in Caregiver Program, just over 2,000 caregivers\(^1\) immigrated to Canada under the Live-in Caregiver Program. As of 2014, 23,174 caregivers obtained work permits as a live-in caregiver (CIC, 2016b). Further, the Philippines represents the top ranked country of origin for caregivers (CIC, 2016b). Specifically, of the individuals immigrating to Canada under the Live-in Caregiver Program, over 90 percent were women and approximately 90 percent originated from the Philippines (Kelly et al., 2011).

Despite the growth of Filipina live-in caregivers in Canada and important role they play in fulfilling labour shortages unwanted by the Canadian population, little to no research has examined the population of immigrant Filipina live-in caregivers (but see Pratt, 1997, 2004, 2009). While the work of Pratt demonstrates how immigrant Filipina live-in caregivers are a vulnerable population in that the work conditions lead to abuse and exploitation and family separation, no research has examined the health and wellbeing of this immigrant population. Numerous qualitative and quantitative studies have studied the links between immigration and health and access to health care services among the general Canadian population and other immigrant populations (e.g. refugees, seasonal agricultural workers) (Ahmad et al., 2004a; 2004b; Alegria et al., 2008; Ali, 2002; Anson, 2004; Arias et al., 2010; Asanin Dean & Wilson, 2008; 2010; Betancourt & Roberts, 2010; Borrell & Lancet, 2012; Breslau et al., 2009; Chen et al., 1996; Cook et al., 2009; Deboosere & Gadeyne, 2005; Elliott & Gillie, 1998; Gadd et al.,

\(^1\) The term ‘domestic worker’ and ‘caregiver’ will be used interchangeably.
2006; Jafari, Baharlou & Mathias, 2010; McDonald & Kennedy, 2004; Menezes, Georgiades & Boyle, 2011; Newbold, 2006; Ng, 2011; Omariba, Ng & Vissandjee, 2014; Palloni & Arias, 2004; Puyat, 2013; Schaffer et al., 2009; Setia et al., 2012; Singh & Siahpush, 2001; Stafford, Newbold & Ross, 2011); only one study has examined access to health services among live-in caregivers (Atanackovic & Bourgeault, 2014) and no research has examined the health and well-being of immigrant Filipina live-in caregivers in Canada.

Therefore, the goal of this research is to examine how the Live-in Caregiver Program affects the health of immigrant Filipina live-caregivers in the Greater Toronto Area, Ontario. To achieve this goal a number of research objectives have been identified:

i. examine live-in caregivers’ work experiences in Canada

ii. investigate the relationship between employment as a live-in caregiver and health

iii. examine how employment as a live-in caregiver affects access to health care

iv. investigate how social support impacts the health and well-being of Filipina caregivers.

This research study is important to the field of health geography because it explores how migration from one country to another influences health, but also examines how being bound within a space (i.e., living in the place of employment) impacts health.

1.1 Thesis Outline

This thesis is composed of five chapters. The second chapter provides a review of the literature examining the links between immigration and health and the health of Filipina caregivers around the globe. The second chapter’s also reviews known literature focusing on live-in caregivers in Canada. Gaps within the literature are identified in chapter two.
The third chapter focuses on methods. Specifically, in Chapter 3, a discussion of recruitment strategies and data collection methods (i.e. in-depth semi-structured interviews) is presented. In addition, Chapter 3 explains how the qualitative interview data were analyzed and the steps taken to ensure rigour was established throughout the research process.

The findings from the twenty-one interviews are presented in Chapter Four. Migration expectations among Filipina caregivers prior to immigrating to Canada are first discussed. Following this, perceived links between work conditions as a live-in caregiver and physical and mental health and access to health care services among Filipina caregivers are presented.

The final chapter provides a summary of the key results and discusses the importance of the research findings. After identifying the key results, Chapter 5 includes a discussion of study limitations and makes suggestions for future research. Chapter 5 closes with recommendations for the Live-in Caregiver Program pertaining to the regulation of work contacts and the implementation of third party health insurance.
Chapter 2

2 Literature Review

2.1 Introduction

The following chapter aims to provide an in-depth overview of migration and health with a specific focus on temporary migrants. This chapter is divided into three main sections. The first section provides a background on literature exploring the relationship between immigration and health in Canada. The second section examines literature on the health of temporary foreign workers in Canada. In the final section, the literature focuses on the health of caregivers globally then discusses the literature exploring the experiences of individuals immigrating to Canada under the (Live-in) Caregiver Program. The chapter concludes with stating the gaps within the current literature and how this study will build on current literature.

The number of international migrants has been increasing rapidly worldwide. As of 2015, the highest number of international migrants was recorded at 244 million, which was 41 percent higher than the number of international migrants recorded in 2000 (United Nations, 2016). The majority of international migrants resided in high-income countries with Canada being one of the top eight destinations (United Nations, 2016).

In Canada, international migrants account for 20 percent of the total population with approximately 250,000 individuals immigrating to Canada each year (Statistics Canada, 2015a). International migrants play an important role in Canada’s economic, social and cultural development by filling labour shortages and strengthening the nation as a whole (Citizenship and Immigration Canada, 2016b). In Canada, individuals can immigrate under four categories: the economic class, family class, refugees and other (CIC, 2015a). Individuals immigrating under the
economic classes are individuals starting up businesses such as entrepreneurs, self-employed individuals as well as investors (CIC, 2015a). The economic class also includes skilled workers, live-in caregivers and provincial nominees (CIC, 2015a). Individuals immigrating under the family class are individuals closely related to individuals residing in Canada which include spouses and partners, children, and parents and grandparents (CIC, 2015a). Refugees as well as their dependents are persons immigrating to Canada with the assistance of the government or private sponsorship due to a fear of persecution or are unable to return to their home country (CIC, 2015a). Individuals classified under the ‘other’ category include retirees, individuals holding a temporary resident permit and individuals accepted for humanitarian and compassionate reasons (CIC, 2015a).

According to Citizenship and Immigration Canada, between 1996 and 2014 the number of individuals immigrating under the family class has mostly remain constant, while the number of individuals immigrating to Canada as refugees or other has decreased (see Figure 1) (CIC, 2015a). The number of immigrants entering Canada under the economic class (53 percent of immigrants in 2014) has increased from 61,618 individuals in 2005 to 78,107 individuals in 2014 (CIC, 2006; 2015).

2 According to Citizenship and Immigration (2015), provincial nominees are individuals nominated by the province or territory in Canada. Skills, education and work experience and a desire to live in the province of territory contribute to the immigrant’s eligibility.
While the number of individuals immigrating to Canada as permanent residents has remained stable from 2005 to 2014, the number of individuals immigrating to Canada temporarily through various work programs has increased (CIC, 2016b). For example, 177,704 international migrant workers migrated to Canada under the Temporary Foreign Worker Program in 2014 as compared to 95,193 in 2005 (CIC, 2016b). The Temporary Foreign Worker Program includes the (Live-in) Caregiver Program and the Seasonal Agricultural Workers Program. The (Live-in) Caregiver Program saw a large increase of immigrants from 22,680 individuals in 2005 to 41,707 individuals in 2009; however, in recent years the program has since seen a decrease in granted work permits which has been suggested to be due to a decline in applications, low acceptance rate and a backlog in granting permanent residency to eligible caregivers (CIC, 2015a; Keung, 2015). In contrast, the number of individuals immigrating to Canada through the Seasonal Agricultural Workers Program has continuously increased between 2005 to 2014 (CIC, 2015a).
Table 1: Temporary Foreign Worker Program Work Permit Holders by Program, 2005-2014 (CIC, 2015a)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agricultural Workers</td>
<td>22,089</td>
<td>24,968</td>
<td>29,144</td>
<td>35,575</td>
<td>34,510</td>
<td>35,420</td>
<td>36,636</td>
<td>38,256</td>
<td>41,697</td>
<td>45,281</td>
</tr>
<tr>
<td>Program work permit holders</td>
<td>50,491</td>
<td>57,790</td>
<td>76,438</td>
<td>104,478</td>
<td>115,516</td>
<td>109,783</td>
<td>94,997</td>
<td>99,199</td>
<td>111,788</td>
<td>109,847</td>
</tr>
<tr>
<td>Other higher-skilled</td>
<td>46,352</td>
<td>51,590</td>
<td>61,660</td>
<td>73,355</td>
<td>72,208</td>
<td>73,623</td>
<td>67,205</td>
<td>69,784</td>
<td>76,278</td>
<td>69,929</td>
</tr>
<tr>
<td>Other lower-skilled</td>
<td>4,064</td>
<td>5,844</td>
<td>14,523</td>
<td>31,543</td>
<td>39,363</td>
<td>38,098</td>
<td>29,875</td>
<td>31,813</td>
<td>38,655</td>
<td>41,002</td>
</tr>
<tr>
<td>Other Occupations</td>
<td>382</td>
<td>624</td>
<td>674</td>
<td>765</td>
<td>780</td>
<td>733</td>
<td>907</td>
<td>956</td>
<td>987</td>
<td>891</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>95,193</strong></td>
<td><strong>110,021</strong></td>
<td><strong>140,804</strong></td>
<td><strong>177,601</strong></td>
<td><strong>191,139</strong></td>
<td><strong>184,022</strong></td>
<td><strong>167,304</strong></td>
<td><strong>165,121</strong></td>
<td><strong>176,541</strong></td>
<td><strong>177,704</strong></td>
</tr>
</tbody>
</table>
Individuals immigrating to Canada as permanent immigrants as well as those migrating temporarily through the Live-in Caregiver Program or the Seasonal Agricultural Workers Program are required to undergo a medical exam through Citizenship and Immigration Canada’s Health Screening and Notification Program CIC, 2015b; 2016c). According to the Immigration, Refugees and Citizenship Canada (2016c), a medical examination can include a physical and mental examination, a review of past medical history, laboratory and diagnostic tests as well as an assessment of medical records to detect infectious diseases/conditions such as tuberculosis (CIC, 2015b). The Health Screening and Notification Program limits entries of individuals who may pose health and safety risks in Canada and/or place a burden on the health and social services in Canada. (CIC, 2016). Protecting the health and safety of Canadians is another reason why health screening among immigrants is used prior to immigration to Canada (CIC, 2016). As a result of intensive medical screening, immigrants tend to be much healthier than the Canadian-born population. However, research has shown how international migrants have been disadvantaged with declining health as their health became similar to or lower than the Canadian-born population (Ali, 2002; Chen, 1996; Mcdonald and Kennedy, 2004; Newbold and Danforth, 2003).

2.2 Immigration and Health

There is a large body of literature in Canada, the United States and Europe that has focused on the links between immigration and health. This research is largely quantitative and relies on national survey data (Aglipay, Colman, Chen, 2013; Alegria et al., 2008; Ali, 2002; Anson, 2004; Arias et al., 2010; Beiser & Hou, 2014; Betancourt & Roberts, 2010; Borrell & Lancet, 2012; Breslau et al., 2009; Chen et al., 1996; Choi (2012); Cook et al., 2009; Gadd, Johansson, Sundquist, & Wandell, 2006; McDonald & Kennedy, 2004; Menezes, Georgiades & Boyle,
This important work has demonstrated the existence of a ‘healthy immigrant effect’ wherein recent immigrants are observed to initially have superior health (e.g., lower rates of mortality, lower prevalence of chronic conditions and mental illness) compared to the native-born population, but over time health declines to levels similar to or lower than the native-born population (Alegria et al., 2008; Ali, 2002; Anson, 2004; Arias et al., 2010; Betancourt & Roberts, 2010; Borrell & Lancet, 2012; Breslau et al., 2009; Chan et al., 1996; Cook et al., 2009; Deboosere & Gadeyne, 2005; Gadd et al., 2006; McDonald & Kennedy, 2004; Menezes, Georgiades & Boyle, 2011; Newbold, 2006; Ng, 2011; Omariba, Ng & Vissandjee, 2014; Palloni & Arias, 2004; Puyat, 2013; Schaffer et al., 2009; Setia et al., 2012; Singh & Siahpush, 2001; Stafford, Newbold & Ross, 2011).

Immigrants’ health advantage over the native-born populations may be the result of self-selection and medical screening (Asanin and Wilson, 2010; Jasso, et al., 2004; Ali, McDermott, & Gravel, R., 2004). It has been argued that Canada’s lengthy and expensive immigration process results in physically and mentally healthier individuals as well as those who are financially able to endure the migration process in comparison to individuals remaining in their country of origin (Asanin and Wilson, 2010; Kennedy, Mcdonald, & Biddle, 2006). Additionally, required medical screening filters out those individuals who are deemed too unhealthy to be accepted for immigration.

For example, using data from the 1994/95 National Population Health Survey, Chen et al. (1996) found that immigrants were healthier than the Canadian-born population with lower levels of chronic conditions and long-term disabilities; however, the rates of some chronic
conditions (e.g., allergies, hypertension, headaches, heart conditions and strokes) and long-term disabilities became comparable to the Canadian population among immigrants who resided in Canada for more than 10 years. Non-European immigrants were also found to have lower overnight hospitalization rates in comparison to both the Canadian-born population and European immigrants (Chen et al., 1996). The number of physician visits and reported unmet health care needs did not vary significantly between immigrants and the Canadian born population (Chen et al., 1996). McDonald and Kennedy (2004) and Newbold (2006) observed similar findings using data from the 1994/95, 1996/97, 1998/99, 2000/01 National Population Health Survey and the 2000/01 Community Health Survey. Specifically, their research showed that immigrant men and women were less likely to be diagnosed with a chronic condition when compared to Canadian men and women; however, over time the number of chronic conditions experienced by immigrants were observed to increase.

More recent findings in a study by Betancourt and Roberts (2010), using data from the 2007/08 Canadian Community Health Survey, showed that immigrants are 40 percent less likely to report chronic diseases in comparison to the Canadian-born population; however, over time, this health advantage lessened. Specifically, recent immigrants, immigrants who had resided in Canada for less than five years, were 60 percent less likely than the Canadian-born population to report a chronic disease while immigrants who had resided in Canada for more than five years were 30 percent less likely to report a chronic disease (Betancourt & Roberts, 2010). Further, using data from the 2009/10 Canadian Community Health Survey, Beiser and Hou (2014) found that 31.7 percent of recent immigrants residing in Canada for ten years or less reported at least one physical condition as compared to 52.9 percent of immigrants whom resided in Canada for more than ten years and 51.1 percent of the Canadian-born population. In the United States, research by Choi (2012) found a similar trend among recent immigrants (individuals residing in
the United States for less than 15 years). Using data from the Second Longitudinal Study of Aging (1994-2000) Choi (2012) reported that recent immigrants had a lower number of chronic conditions such as osteoporosis, diabetes, arthritis, bronchitis, asthma, hypertension heart disease and cancer in comparison to immigrants who resided in the United States for 15 or more years and the U.S.-born population. Further, in Europe, Mejean et al. (2007) observed that Tunisian immigrants in France had a lower likelihood of diet-related chronic diseases in comparison to the native-born population. Another study by Buja et al. (2013) found that immigrants in Italy had significantly lower rates of congestive heart failure and coronary heart disease in comparison to the Italian-born population.

In addition to physical health conditions, research has also shown differences in mental health between immigrant populations and the Canadian-born population (Ali, 2002; Menezes, Georgiades & Boyle, 2011; Puyat, 2013; Schaffer et al., 2009; Setia et al., 2012; Stafford, Newbold & Ross, 2011). Using data from the 2002 Canadian Community Health Survey Menezes, Georgiades and Boyle (2011) found that immigrants were associated with a lower prevalence of mood disorders, anxiety disorders, substance dependence and schizophrenia or other lifetime prevalent psychotic disorders when compared with the Canadian-born population. Research by Ali (2002) using data from the 2000/01 Canadian Community Health Survey showed that immigrants, particularly recent immigrants (defined as those living in Canada for less than 14 years) and immigrants originating from Africa and Asia, have lower rates of depression and alcohol dependency while longer term immigrants (i.e., immigrants whom have resided in Canada for more than 14 years) were seen to have similar rates of depression in comparison to the Canadian-born population. A longitudinal analysis of the 1994-2006 National Population Health Survey by Setia et al. (2012) found that non-white immigrants were less likely to report severe psychological distress; however, the prevalence of reported severe psychological
distress increased in immigrant men and not women in later years. Stafford, Newbold and Ross (2011) also found that immigrants were less likely to experience depression in comparison to the Canadian-born population. Similarly, work by Puyat (2013), using data from the 2009/10 Canadian Community Health Survey, shows that immigrants have the lowest prevalence of mood or anxiety disorders when compared with the Canadian-born population. Research by Aglipay, Colman and Chen (2013) showed similar results with a specific emphasis on the differences between recent immigrants, (e.g. those who had resided in Canada for less than ten years) and long-term immigrants who had resided in Canada for ten or more years. While recent immigrants were found to have a lower prevalence of anxiety disorders in contrast to the Canadian-born population, long-term immigrants also had a lower prevalence of anxiety disorders in comparison to the Canadian-born population; however, to a lesser extent than recent immigrants (Aglipay, Colman & Chen, 2013). Similarly, Wu and Schimmele (2005) also demonstrate the lessening of the mental health advantage over time among immigrants. The occurrence of life-time prevalent psychotic disorders, specifically bipolar disorder, was studied by Schaffer et al. (2009) who found that immigrants were less likely to be diagnosed with bipolar disorder compared to Canadian-born population. Similar results have been found regarding the differences in mental health among immigrant populations and the native-born population in the United States (Alegria et al., 2008; Breslau, et al., 2009; Cook, et al., 2009). However, contradictory evidence suggesting that the mental health of immigrants, particularly the probability of depression, fared worse among immigrants compared to the native-born population in the United States (Gonzalez, Haan, Hinton, 2001) and in Europe (Ladin & Reinhold, 2013).

Research examining differences in the rate of mortality among immigrant populations compared with the Canadian-born population has also been studied by a number of researchers.
For example, Omariba, Ng and Vissandjee (2014) using data from the 1991-2006 Canadian Census Mortality and Cancer Follow-up Study observed that immigrant men had a 22 percent lower risk of mortality while immigrant women had a 17 percent lower risk of mortality compared to the Canadian-born population. That said, their research also showed that the mortality advantage lessened with both immigrant men and women found to have a risk of mortality closer to the Canadian-born population as the duration of residence in Canada increased. When observing the origin countries of immigrants, Omariba, Ng and Vissandjee (2014) found that immigrants from China, the Caribbean, India and the Philippines were found to have a mortality lower than immigrants originating from the UK as individuals from the UK reflected a longer residency in Canada. Similarly, Ng (2011) also observed significantly lower mortality rates among immigrant groups compared to the Canadian-born population and mortality rate similar to those of the Canadian-born population among immigrant groups whom spent more time in Canada. Likewise, studies from Europe (Anson, 2004; Deboosere & Gadeyne, 2005; Gadd et al., 2006) and the United States (Arias et al., 2010; Borrell & Lancet, 2012; Palloni & Arias, 2004; Singh & Siahpush, 2001) have noted similar trends in mortality rates among immigrant groups compared to the native born-population.

Linked to the above research are a number of studies that attempt to explain reasons for the decline in immigrant health. Some research has hypothesized that the decline in the health of immigrants may be a result of acculturation. Studies focusing on acculturation have noted an increase in immigrants’ body mass index (McDonald & Kennedy, 2005; Setia et al., 2009), poorer dietary habits (Akresh, 2007; Gilbert & Khokhar, 2008), an increase alcohol consumption (Hahm, Lahiff, & Guterman, 2004), an increase in tobacco use (Castro et al., 2012) and an increase in sedentary behaviours (Murillo et al., 2015).
In addition to acculturation, some argue that a decline in health status may be due to immigrants’ under-utilizing health services (McDonald & Kennedy, 2004). Immigrants have been found to under-utilize health services compared to the Canadian-born population (Chen, 1996; Gagnon, 2002; Hyman, 2001; Laroche, 2000). Research by Sanou et al. (2014) has found as time in Canada increases immigrants experience an increase in health care use. With evidence suggesting that the use of health care increases among immigrants, Newbold (2005) cautions that increased utilization does not necessarily mean that the health care needs of immigrant populations have been met. Unmet health care needs among immigrants may be because of barriers to health care which as a result, may lead to declining health (Asanin Dean and Wilson, 2010). The literature has demonstrated that immigrants face numerous barriers to accessing health care services including language and culturally appropriate approaches, lack of awareness of existing health information and services available, as well as barriers which may be the result of settlements experience such as low income, social exclusion, social isolation, or a lack of social support (Ahmad et al., 2004a; 2004b; Asanin Dean & Wilson, 2008; Clough, Lee & Chae, 2013; Jafari, Baharlou, & Mathias, 2010; Lai & Chau, 2007; Sutton et al., 2007; Thomson et al., 2015)

While the quantitative literature (Chen, Ng, & Wilkins, 1996; Newbold & Danforth, 2003; Kennedy, McDonald & Biddle, 2006; Newbold, 2005; Ng, 2011) provides fairly clear evidence of the existence of a healthy immigrant effect, studies tend to focus on the general immigrant population with little to no distinction between different groups of immigrants (e.g., temporary foreign workers, refugees). This is mainly related to inherent limitations of the public use microdata files (PUMF) for national surveys. For example, in the Canadian Community Health Survey (the most widely utilized health survey in the country), respondents can indicate their country of origin as well as their ethnicity; however, data is not collected about the category
under which they immigrated to Canada. Respondents simply either respond ‘yes’ or ‘no’ to being a landed immigrant. Similarly, in the National Longitudinal Survey of Immigrants, individuals indicate whether they are Canadian-born, a landed immigrant, refugee or other. As a result, the lack of collected data in regards to specifying the categories to which immigrants arrive to Canada under (e.g., economic, family) limits our understanding of how immigrants’ health is affected over time as well as limits the ability to compare the similarities and differences in health between immigrants (e.g., permanent immigrants vs. temporary immigrants). An expanding body of qualitative research has begun to examine the immigration and health for specific subgroups of the immigrant population including newcomers, Mainland Chinese, Indian, South Asian Fijian and Iranian immigrants (Ahmad et al., 2004a; 2004b; Asanin Dean & Wilson, 2008; 2010; Elliott & Gillie, 1998; Jafari, Baharlou & Mathias, 2010).

While very few studies examine changes in health status over time, one study by Asanin Dean and Wilson (2010) examined perceived changes in health status among recent, mid-term and long-term immigrants originating from a variety of countries (mostly from South Asia and Eastern Europe) residing in the Greater Toronto Area. The majority of the 23 participants interviewed in the research study reported to have stable or improved health due to improved lifestyle and standard of living in Canada; however, participants who reported a decline in health status since immigrating to Canada associated the decline with stress from migration and aging (Asanin Dean and Wilson, 2010). Ahmad et al. (2004a) similarly noted a decline in health among 22 Mainland Chinese and 24 Indian immigrants in the Greater Toronto Area. Ahmad et al. (2004a) conducted eight semi-structured focus groups to examine the health and physical concerns after immigration and noted that participants expressed feeling of loneliness and depression as well as headaches and fatigue. Job and financial uncertainties, the different lifestyle in Canada compared to India (e.g., more hectic in Canada with inadequate leisure time),
and changes in climate and diet were also found to affect the mental and physical health of immigrants from India (Ahmad et al., 2004b). Interviews conducted by Elliott and Gillie (1998) with South Asian Fijian women and service providers working with the participants unveiled physical health problems related to stress in the first three months of immigrating to Canada, fatigue looking for employment and the change in weather. Emotional health problems as a result of immigrating were also disclosed such as worrying, loneliness, homesickness and depression (Elliott & Gillie, 1998). Furthermore, in a study of six focus groups and 10-indepth interviews with Iranian immigrants in British Columbia, Jafari, Baharlou and Mathias (2010) stated that factors affecting mental health were English fluency, difficulties making friends due to cultural differences, and difficulties finding employment.

When investigating the health status among immigrants, several qualitative studies have linked health status with barriers to accessing health care services (Ahmad et al., 2004a; 2004b; Asanin Dean & Wilson, 2008; 2010; Elliott & Gillie, 1998; Jafari, Baharlou & Mathias, 2010; Lai & Chau, 2007; Sutton et al., 2007). For example, in a study of immigrants residing in Mississauga, Ontario, Canada, Asanin Dean and Wilson (2008) identified geographic, socio-cultural and economic barriers to accessing access health services. In collaboration with the Dixie Bloor Neighbourhood Centre, Asanin Dean and Wilson (2008) specifically found that difficulties finding family physicians in the local area accepting new patients (i.e., geographic), language issues and culturally inappropriate medical treatment (i.e., sociocultural) and the cost of receiving health services as some participants who were not yet eligible for Ontario Health
Insurance Plan\(^3\) either did not seek medical care or paid out of pocket (i.e., economic) (Asanin
Dean and Wilson, 2008). Ahmad et al., (2004a) identified key barriers such as long wait times to see a specialist or care in the hospital’s emergency, a lack of quality care from health care professionals, a lack of familiarity with the healthcare system, a loss of social networks, language barriers, and transportation barriers (Ahmad et al., 2004a; 2004b). South Asian Fijian participants in the study by Elliott and Gillie (1998) also faced language and financial barriers when accessing health care services. Using verbally administered structured questionnaires, Lai and Chau (2007) also found that being unable to communicate with health care professionals, long wait lists to see health care professionals and a lack of knowledge about existing health services were the top three barriers to accessing health services among Chinese immigrants in seven Canadian cities (specific cities not mentioned in the study). As a result, barriers to accessing health services has mostly led to a worsened health status.

Barriers to accessing health services were also found in studies conducted in the United States of America. Leung et al. (2014) found that among the twenty-seven Chinese immigrants whom participated in six semi-structured focus groups and two individual interviews, personal barriers (e.g. short attention spans), cultural barriers, language barriers, the expensive cost of care and transportation were obstacles for Chinese immigrants to obtain and understand health information. Similar barriers to accessing health care such as lack of insurance and resources, costly services and language barriers was found by Sangaramoorthy and Guevara (2016) who interviewed 33 individuals who were Latino and Haitian immigrants as well as health and social service providers in rural Maryland, United States.

\(^3\) In Ontario, newcomers must undergo a three-month waiting period until they are eligible for the Ontario Health Insurance Plan (OHIP). Once eligible, OHIP coverage includes medically necessary services (e.g., doctor visits), dental services done in a hospital, and eye examinations for individuals under 20 and over 65.
Qualitative research on immigration and health tends to focus on understanding health status and barriers to accessing health care services faced by immigrant populations in general and growing immigrant populations in Canada (e.g., Chinese and Indian immigrants); however, most studies neglect to report on the categories of immigrants included in research. A handful of studies have examined the health of refugees (DesMeules et al., 2005; Miedema, Hamilton & Easley, 2008; Pottie, et al., 2007), only a very small number of research studies have focused on the health status and barriers to accessing health care services among temporary foreign workers.

### 2.3 Temporary Migration and Health

Understanding the health of temporary foreign workers is of significant importance as Canada relies on economic immigrants, such as temporary foreign workers, for a number of reasons including to strengthen the national economy and to fill labour shortages in specific sectors (CIC, 2016b).

Literature focusing on the health of migrant workers in Canada is limited and has mainly focused on seasonal agricultural workers in Ontario, British Columbia and Quebec (Hanley et al., 2014; Hennebry, 2010; McLaughlin, Hennebry & Haines, 2014; Narushima, McLaughlin, Barrett-Greene, 2015; Narushima & Sanchez, 2014; Preibisch & Otero, 2014; Salami, Meharali, & Salami, 2015). The research demonstrates health issues experienced by temporary foreign workers as well as barriers to accessing health care services in Canada (Hanley et al., 2014; Hennebry, 2010; McLaughlin, Hennebry & Haines, 2014; Narushima, McLaughlin, Barrett-Greene, 2015; Preibisch & Otero, 2014; Salami, Meharali, & Salami, 2015).

For example, in a study by Preibish and Otero (2014), 200 questionnaires completed by South Asian and Mexican immigrant farm workers in British Columbia showed that immigrant farm workers experienced unsanitary and unsafe work and housing conditions that resulted in
illness and injury. The researchers also showed that as a result of fearing a loss of hours, deportation and impacts on future employment, South Asian and Mexican immigrant farm workers continued to work when ill or injured and avoided reporting health issues to employers. Hennebry (2010) found similar poor living and working conditions using data collected from standardized questionnaires among 576 Mexican and Jamaican temporary migrant agricultural workers in Southern Ontario. McLaughlin, Hennebry and Haines (2014) use data from 100 questionnaires completed by foreign agricultural workers whom previously reported health issues or injuries while working in Ontario found a link between poor health and a lack of health and safety training in the workplace.

Commonly found barriers to accessing healthcare services among temporary foreign workers include language differences between immigrants and employers of health care professionals as well as a lack of transportation to health care locations due to being in a remote area (Hanley et al., 2014; Hennebry, 2010; Preibish & Otero, 2014). Additionally, Hanley et al. (2014) conducted 211 surveys and 31 follow-up interviews with temporary foreign workers in Montreal to understand immigrants’ experiences accessing health care. In addition to language and transportation barriers to accessing health care services, Hanley et al. (2014) found that professionals refusing to accept uninsured individuals, the high cost of services, the lack of knowledge about where to receive care, difficulties acquiring time off work and discrimination, prevented temporary foreign workers from receiving care. Narushima, McLaughlin and Barrett-Green (2015) likewise demonstrate that the lack of knowledge related to understanding Canada/Ontario’s health care system and the struggle to find time to make an appointment and see a health care professional because of an unpredictable work schedule are obstacles to receiving health care among Caribbean and Mexican migrant farm workers in Ontario. The fear
of deportation was also seen to be a barrier to accessing health care for temporary foreign workers in a study by Hennebry (2010).

In summary, the small body of literature focusing on temporary migration and health in Canada has mainly focused on seasonal agricultural workers (Hanley et al., 2014; Hennebry, 2010; McLaughlin, Hennebry & Haines, 2014; Narushima, McLaughlin, Barrett-Greene, 2015; Preibisch & Otero, 2014; Salami, Meharali, & Salami, 2015). Little to no research has focused on health status and access to health care among other temporary foreign workers in Canada such as immigrant caregivers (Atanackovic & Bourgeault, 2014). While the literature on seasonal agricultural workers in Ontario, British Columbia and Montreal provides significant insight on the health experiences among temporary foreign workers, it is important to study the health experiences of other groups of temporary foreign workers, particularly immigrant caregivers.

2.4 Filipina Caregivers and Health: Global Perspective

According to the Philippine Overseas Employment Administration (unpublished data set), Hong Kong was the top destination for Filipina domestic workers in 2010. As a result, existing literature examining the health of Filipina domestic workers has predominately focused on the population of Filipina domestic workers residing in Hong Kong (Bagley, Madrid & Bolitho, 1997; Holroyd, Molassiotis, & Taylor-Pilliae, 2001; Margallo & Peligro, 2014; van der Ham et al., 2014) with some limited research conducted on the health of Filipina domestic workers in Israel (Ayalon, 2012; Ayalon & Shiovitz-Ezra, 2010). Only one study has focused on the health experiences of Filipina caregivers in Canada (Atanackovic & Bourgeault, 2014).

For instance, in a study by Holroyd, Molassiotis & Taylor-Pilliae (2001), an inability to get a good night sleep, waking up early, and feelings of loneliness and worry were the main symptoms of mental distress among 290 Filipina domestic workers surveyed in Hong Kong.
Further, Bagley, Madrid and Bolitho (1997) revealed that employment related issues, debt and familial issues and separation from family and friends were key stress factors affecting mental health among Filipina domestic workers in the Philippines. However, good mental health was found among Filipina domestic workers who did not have children, had a high level of education, no debts, strong ties to Filipino social organizations in Hong Kong, knowledgeable with Cantonese, a higher income and regularly visited the Philippines (Bagley, Madrid, & Bolitho, 1997).

In a study by Ayalon and Shiovitz-Erza (2010) in Israel, in-depth interviews with Filipino caregivers shows how feelings of emotional and social loneliness impact the emotional and physical health among participants. Filipina caregivers not only found it emotionally difficult to return and leave their families during moments of temporary reunification, but Filipina caregivers were also unable to form strong relationships with their employers due to their old age and difficulties adjusting to the different language and culture upon arrival (Ayalon & Shiovitz-Erza, 2010). Physically, loneliness leads to medical conditions (not specified in the study) as a result of losing weight, sleep deprivation and a heavy work load. Moreover, quantitative research using the Paykel Suicide Scale to measure feelings of suicide and the Patient Health Questionnaire to measure depressive symptoms found that Filipino caregivers in Israel exposed to moderate levels of abuse and discrimination report high levels of suicide attempts, and symptoms of depression associated with abuse within the work environment (Ayalon, 2012).

Margallo and Peligro (2014) investigated how working abroad (no particular country specified) and being away from their families, generally, affected the stress and wellbeing of Overseas Filipino Workers, demonstrating how multiple factors (e.g., health, work, family, financial) affect stress. The highest factor influencing the stress experienced amongst Overseas
Filipino Workers were factors pertaining to the caregivers’ family’s financial security (Margallo & Peligro, 2014). When investigating the level of well-being among Overseas Filipino Workers using body, mind, mood and temperament, social, lifestyle and goal indicators, Overseas Filipino Workers were noted as having a well-being seen as satisfactory when working abroad (Margallo & Peligro, 2014). However, because the majority of the sample represented in the study were male overseas workers, and the specific occupations taken on by Overseas Filipino Workers were not identified (e.g., engineers vs. nurses vs. caregivers), the study neglected to demonstrate how gender and occupation can affect the stress and wellbeing of Overseas Filipino Workers.

van der Ham et al. (2014) also looked at understanding how stress is experienced by Filipina domestic workers globally. Data collection took place in the Philippines using questionnaires that were validated in workshops among stakeholders and focus groups at different phases of migration. The average stress level among Filipina domestic workers was significantly highest during migration, second highest prior to migration and the least high after migration (van der Ham et al., 2014). Women with partners and/or children were seen to have higher levels of stress when compared to women who were single or without children before and after migration (van der Ham et al., 2014). Causes of stress before migration were related to financial concerns, specifically, due to the lack of funds to start the application process while stress caused after migration were related to a lack of income (van der Ham et al, 2014). During the migration phase, causes of stress were related to their working conditions, money, family matters, personal safety as well as psychosocial issues such as loneliness, homesickness, and difficulties adjusting to a new place (van der Ham et al, 2014).

The literature has also demonstrated how Filipina domestic workers find support as they employ coping strategies to alleviate declining emotional and mental health (Ayalon and
Shiovitz-Ezra, 2010; Holroyd, Molassiotis, & Taylor-Pilliae, 2001; Nakonz & Shik, 2009; van der Ham et al., 2014). For example, Nakonz and Shik (2009) examined how religious coping strategies among Philippine domestic workers in Hong Kong were used to endure hardships during their time of employment. Hardships identified included loneliness, homesickness, unjust working conditions and worrying about family left behind in the Philippines (Nakonz & Shik, 2009). Coping strategies used to ease the hardships were to give their hardships a religious significance, pray for God to resolve their work and family related issues and engaging in the church’s social services to provide as distraction, a time to share problems, prayers, housing support and political activism (Nakonz & Shik, 2009; van der Ham et al., 2014). Social support networks comprised of families, friends and religious community have also been present among Filipina domestic workers in Hong Kong (Holroyd, Molassiotis, & Taylor-Pilliae, 2001; van der Ham et al., 2014). Philippine domestic workers in Israel coped with mental stressors by justifying their leaving to financial betterment and a better life for themselves and their families and developing relationships with the Israeli family they were working for and the Filipino community (Ayalon and Shiovitz-Ezra, 2010).

2.5 Filipina Caregivers in Canada

Over the past 20 years, an emerging body of literature has begun to shed light on the experiences of live-in caregivers in Canada. Much of the research has focused on how the Live-in Caregiver Program reinforces gendered and racial exploitative work conditions (Hodge, 2006; Khan, 2009; Pratt, 1997; Stiell & England, 1997), leads to distress on family lives (Cohen, 2000; Pratt, 2009), and has examined the ways in which live-in caregivers integrate into Canada’s society (Atanackovic & Bourgeault, 2014).
For example, Pratt (1997; 2004; 2009) was among the first to study the experiences of live-in caregivers. In one of her earlier studies, she documented stereotypes of Filipina and European nannies among agents employed by nanny agencies in Vancouver, British Columbia, Canada (Pratt, 1997). Nanny agents constructed European nannies as professionals, down to earth, tourists, better with older children, cold and controlling while Filipinas were fabricated as servants, uncivilized, loving, patient, gentle with babies, well-educated, and motivated to immigrate to acquire citizenship and bring their families (Pratt, 1997). Agents were therefore seen to act upon these stereotypes and as a result, agents structured expectations and job contracts (e.g., access to jobs, work conditions and wages) accordingly between employers and domestic workers (Pratt, 1997). Filipina nannies were viewed as less than employees; thus unacceptable wage and work conditions were legitimized (Pratt, 1997). For example, in her research, Pratt (1997) found that Filipina domestic workers made $600-$650 monthly as well as did more housework, while European domestic workers made around $800 monthly.

In a study by Stiell and England (1997), 18 in-depth interviews were conducted with live-in caregivers from various countries of origin. Ten participants were categorized as white and 8 participants were classified as non-white. Of the 18 participants, 5 originated from the Philippines. Stiell and England (1997) found that although most women felt exploited working long hours, not being paid overtime, performing tasks not stated in their contract and having limited days off, caregivers categorized as white experienced employment with better hours and little to no housework in comparison to caregivers categorized as non-white. Hodge (2006) further emphasizes how some women under the Live-in Caregiver Program are valued more than others based on their race.

The unjust gendered and racial treatment inherent in the (Live-in) Caregiver Program has not only been seen to affect the lives of Filipina caregivers, but has also been seen to affect their
families. Cohen (2000) examines how the policies of Live-In Caregiver Program shape the private lives of Filipina caregivers and their families. Cohen (2000) interviewed 11 Filipina caregivers, 1 immigration officer, and 2 counselors and 2 community workers from INTERCEDE (a non-government organization) in Toronto, Ontario, Canada. Because live-in caregivers cannot immigrate to Canada with their families under the (Live-in) Caregiver Program, the relationships that emerge once caregivers are reunited with their spouses and children is seen to be problematic (Cohen, 2000). Cohen (2000) states that sponsored family members feel estranged from the caregiver and families struggle to rebuild their lives together in Canada after several years of separation. (Cohen, 2000). Similarly, a study by Pratt (2009) in collaboration with an activist group at the Kalayaan Center in Vancouver, Columbia uses a collection of life narratives including stories about family separation and traumatic returns to examine how the Live-in Caregiver Program impacts the lives of Filipina caregivers and their families. In Pratt (2009), the narratives expressed in the study demonstrate how Filipina caregivers were stigmatized as bad mothers by individuals from the Philippines and in Vancouver.

Understanding experiences of economic integration as well as social integration during and after the Live-in Caregiver Program (not just individuals originating from the Philippines) was examined by Atanackovic and Bourgeault (2014). Economic integration was defined as a live-in caregiver’s ability to earn a paying job, their work conditions, and whether their credentials matched their work experience during and after the Live-in Caregiver Program. Social integration was measured as how well live-in caregivers engaged with the Canadian society. Atanackovic & Bourgeault (2014) conducted interviews and focus groups in Ontario, British Columbia, and Quebec among 58 live-in caregivers and 5 policy informants (i.e., representatives from Citizenship and Immigration Canada, Human Resources and Skills
Development Canada, a live-in caregiver organization, an immigrant services agency and academia). Live-in caregivers reported they were hesitant to confront issues related to abuse, privacy violations, access to education, health care and services related to immigrant settlement because of their temporary status (Atanackovic & Bourgeault, 2014). Having temporary status places foreign caregivers at the risk of being sent back to their country of origin if they are without employment and cannot complete the requirements of the (Live-in) Caregiver Program. Atanackovic and Bourgeault (2014) note that the live-in requirement and a lack of free time and money, particularly for caregivers caring for adults as opposed to children, are seen to influence social integration among live-in caregivers as they are unable to reach organizations or are unaware of their existence leading to feelings of social isolation and family separation. Interestingly, policy informants explained that employers often breached the work contract in not providing live-in caregivers with third-party health insurance for the first three months in Canada, live-in caregivers in the study did not express this issue (Atanackovic & Bourgeault, 2014).

While the growing literature on Filipina live-in caregivers’ work conditions, family reunification process and settlement experiences in various urban settings in Canada (e.g. Toronto, British Columbia, Montreal) are important, studies to date have overlooked issues related to health and well-being and access to health services. Thus, it is the goal of this research to further contribute to the existing body of literature on temporary foreign workers by examining the links between employment as a live-in caregiver and health and access to health care services.
2.6 Conclusion

The large body of literature on immigration and health has demonstrated through numerous quantitative studies and a growing number of qualitative studies that immigration affects the health of non-native born populations. Multiple quantitative studies have suggested evidence for the healthy immigrant effect whereby immigrants present a health advantage over the native-born population; however, this advantage lessens overtime (Alegria et al., 2008; Ali, 2002; Anson, 2004; Arias et al., 2010; Betancourt & Roberts, 2010; Borrell & Lancet, 2012; Breslau et al., 2009; Chen et al., 1996; Cook et al., 2009; Deboosere & Gadeyne, 2005; Gadd et al., 2006; McDonald & Kennedy, 2004; Menezes, Georgiades & Boyle, 2011; Newbold, 2006; Ng, 2011; Omariba, Ng & Vissandjee, 2014; Palloni & Arias, 2004; Puyat, 2013; Schaffer et al., 2009; Setia et al., 2012; Singh & Siahpush, 2001; Stafford, Newbold & Ross, 2011). The decline in health status is hypothesized to be related to a number of factors including acculturation as well as a lack of access to health care services. While some qualitative studies have demonstrated a decrease in health status among immigrants due to obstacles such as cultural and linguistic barriers to accessing health services (Ahmad, 2004a; 2004b; Asanin Dean & Wilson, 2008; Elliott & Gillie, 1998; Lai & Chau, 2007; Leung et al., 2014; Sangaramoorthy & Guevara, 2016), other studies have shown that immigrants’ health status has improved or remain stable since arriving in Canada (Ahmad et al., 2004a; 2004b; Asanin Dean & Wilson, 2008; 2010; Elliott & Gillie, 1998; Jafari, Baharlou & Mathias, 2010; Lai & Chau, 2007; Sutton et al., 2007).

Regardless, both quantitative and qualitative studies focusing on immigration and health have neglected to investigate the health of immigrants with temporary status in Canada, particularly those individuals immigrating to Canada under the (Live-in) Caregiver Program. The increasing number of studies focusing on the health of temporary foreign workers in Canada has mostly examined individuals migrating to Canada under the Seasonal Agricultural Workers program.
finding that physical and mental health are negatively affected by poor working and housing conditions as well as difficulties to accessing health care (Hanley et al., 2014; Hennebry, 2010; McLaughlin, Hennebry & Haines, 2014; Narushima, McLaughlin, Barrett-Greene, 2015; Preibisch & Otero, 2014; Salami, Meharali, & Salami, 2015). As a result, a significant gap remains in regards to what is understood about the health status and potential barriers to accessing health care services confronted by Filipina live-in caregivers.

Therefore, the objective of this qualitative study is to examine how the (Live-in) Caregiver Program affects the health of immigrant Filipina caregivers living-in their place of employment. This research will not only build on the large body of literature on immigration and health as whole, but will also contribute to the lack of literature focusing on the health of a growing minority population of temporary foreign workers in Canada, namely, Filipina caregivers.
Chapter 3

3 Research Methods

3.1 Introduction

This research uses in-depth semi-structured interviews to examine how the (Live-in) Caregiver Program affects the health of current and former Filipina caregivers in the Greater Toronto Area, Ontario, Canada. As discussed in Chapter 2, while there is a growing body of qualitative research examining immigration and health, there is a lack of focus on temporary foreign workers in general and the Filipina caregiver population in particular.

This chapter is divided into four sections. The first section provides justification for the use of semi-structured interviews for this population and provides an overview of the specific questions asked of each participant. The second section presents details on the process of participant recruitment and provides an overview of the research participants. The third section discusses the process of data analysis and the final section explains how the overall research design establishes rigour.

3.2 Qualitative Research Approaches

Qualitative methodologies allow researchers to understand and reflect on lived experiences by interpreting individuals’ meanings behind reality (Bryman & Bell, 2016). In-depth interviewing is a popular method for collecting qualitative data. Interviews allow for closed and open-ended question and answering between the researcher and research participant as well as emphasize the importance of research participant’s perspectives of their experiences (Bryman & Bell, 2016).

Dunn (2010) states that research interviews are used for four main reasons:
1. “To fill a gap in knowledge that other methods, such as observation or other use of census data, are unable to bridge efficaciously
2. To investigate complex behaviours and motivations
3. To collect a diversity of meaning, opinion, and experiences. Interviews provide insights into the different opinions or debates within a group, but they can also reveal consensus on some issues.
4. When a method is required that shows respect for and empowers the people who provide the data. In an interview, the informant’s view of the world should be valued and treated with respect. The interview may also give the informant cause to reflect on their experiences and the opportunity to find out more about the research project than if they were simply being observed or if they were completing a questionnaire.” (p.102)

Following Dunn (2010), in this research study, interviews were used to: i) fill the gap in knowledge regarding the links between immigration and health by examining factors influencing the health of live-in caregivers; ii) investigate the complex link between work conditions and the health of caregivers and their access to health care services; iii) collect a diverse collection of perspectives about health status and access to health services as well as experiences in Canada by interviewing new (current) and former caregivers; and iv) empower Filipina caregivers who have been previously shown to be vulnerable to abuse and exploitation due to the requirements of the (Live-in) Caregiver Program (see Hodge, 2006; Pratt 1997; 2004; Tungohan et al. 2015).

Therefore, this research will provide Filipina caregivers with the opportunity to talk about the nature of their employment and the challenges they face working as caregivers.

Semi-structured interviews, which lay between the continuum of unstructured interviews at one end and structured interviews on the other, are a type of interview that contain some structure but still include a sense of flexibility in that the interview can address questions not originally planned at a particular phase of the interview or at all (Bryman & Bell, 2016).

Additionally, while interviews generally allow for individuals to be heard (Dunn, 2010), semi-structured interviews allow more depth of discussion between the interviewer and interviewee (Dunn, 2016). Specifically, interviews give the opportunity for marginalized populations to be
heard as their opinions are often overshadowed by the general public’s opinion (Dunn, 2010).

Therefore, this research study uses in-depth semi-structured interviews because they allow Filipina caregivers to talk about experiences and enable the researcher to gather a wide range of information that may not have been collected if quantitative approaches or closed questioning were used. Semi-structured interviews have been successfully used in other research projects that included similarly vulnerable populations. For example, semi-structured interviews were used by Pratt (2009) to better understand the intimate stories of family separation and its impact on immigrant Filipina caregivers in Canada and their families left behind in the Philippines. Among seasonal agricultural workers in Canada, Preibisch and Otero (2014) used semi-structured interviews to examine how the health and safety of South Asian and Mexican seasonal agricultural workers was compromised because of their work conditions. Mysyk, England and Gallegos’ (2008) used semi-structured interviews to understand how being a seasonal agricultural worker in Ontario affects workers’ mental health. Semi-structured interviews have also shown to be beneficial when examining sensitive topics such as health concerns and access to health care services among a variety of immigrant populations (Asanin and Wilson, 2008; 2010) as well as among specific immigrant populations such as Mainland Chinese and Indian immigrants (Ahmad, 2004a; 2004b) and South Asian Fijian women (Elliott & Gillie, 1998).

The interview questions were divided into four sections. The first section of questions examined live-in caregivers’ experiences before migrating to Canada, their experiences integrating into Canadian society and social support available for participants. The second set of questions focused on the employment experiences of participants while working as live-in caregivers in Canada. Questions regarding employment experiences were based on understandings of work conditions through the academic literature (Pratt, 2004; Atanackovic and Bourgeault, 2014) as well as through information available regarding the Live-in Caregiver
Program on Citizenship and Immigration Canada’s website (CIC, 2014). The third section focused on health related questions. Health related questions were loosely based on some questions in the Canadian Community Health Survey, specifically those pertaining to general health and access to health care services (Statistics Canada, 2015b), but were modified to allow for open-ended responses. The final section of the interview asked about general thoughts immigrant Filipina caregivers had in regards to the (Live-in) Caregiver Program as well as provided an opportunity to discuss topics they felt were important to discuss. Interview questions can be found in Appendix 3.

3.3 Recruitment, Participants and Data Collection

As discussed earlier in Chapter One, the majority of live-in caregivers in Canada are women originating from the Philippines, most of whom settle in Ontario (CIC, 2016). Thus, recruitment of Filipina caregivers focused on the Greater Toronto Area (GTA), Ontario, Canada. A multi-pronged recruitment strategy was used to advertise the research study and recruit potential participants.

First, following the success of other researchers who have recruited live-in caregivers and newcomers from community centres (Pratt, 1997; 2009; Asanin Dean and Wilson, 2008; 2010), organizations across the GTA were contacted to place recruitment posters. Recruitment posters included information on the objective of the research study (i.e., to understand experiences settling in Canada, work experiences as a caregiver under the Caregiver Program, accessibility to health care), participant requirements (i.e., individuals must originate from the Philippines, have a minimum of 6 months working as a caregiver), and my contact information (refer to Appendix 5). In this research study, recruitment posters were posted at the Worker’s Action Centre, a worker-based organization providing information and advice regarding the rights of individuals
in low-wage and unstable employment, including but not limited to live-in caregivers in Ontario. No participants were recruited through the use of posters at the Worker’s Action Centre.

Second, the research study networked with religious organizations for assistance with recruitment. According to the Philippine’s National Statistics Office (2015), approximately 90 percent of the Philippine’s population is Christian. Additionally, Nakonz and Shik (2009) have shown how spirituality is an important coping strategy among immigrant Filipina caregivers when working abroad. As a result, churches with a high attendance of the Philippine community were contacted by phone and email. A high attendance of the Philippine community was based on my experiences attending masses, many of which were conducted in Tagalog. The pastor of the Metropolitan Bible Baptist Church responded to my email with full support. The pastor discussed the research study with all members of the church and directed interested participants to myself during and after the two masses I attended. A recruitment poster was also placed on the church’s bulletin board to allow all interested participants to contact me. In total, three participants were recruited and interviewed through this method at the Metropolitan Bible Baptist Church.

*Figure 2. Recruitment Poster at the Metropolitan Bible Baptist Church*
Third, in order to reach out across the Greater Toronto Area, the recruitment poster was published in the April 8-21, 2016 issue of the Philippine Reporter, a newspaper that was in existence in 1989, circulating 12,000 free copies in the Greater Toronto Area as well as to paid subscribers online. The recruitment poster was published in English and Tagalog. One participant was recruited through the newspaper advertisement.

![Recruitment poster](image)

**Figure 3.** Recruitment poster advertised in the April 8-21, 2016 issue of the Philippine Reporter.

Fourth, a snowball approach was used. Specifically, at the conclusion of each interview, research participants were asked if they knew other potential research participants who may qualify for the study and would be interested in participating. Using the snowball sampling method, ten participants were recruited and interviewed. Those interviewed through the snowball
sampling method were friends of research participants who had met during or after their time working as a live-in caregiver under the Live-in Caregiver Program. Cohen and Arieli (2011) state that the snowball sampling method is an effective method in cases involving marginalized populations who are ‘hidden’ and ‘hard to reach’ for outsider researchers who differ substantially from the research participants (Dowling, 2010). Lastly, 5 research participants contacted me through individuals within the Filipino community with whom I have personal relations (e.g., family members, previous colleagues).

In recruiting and interviewing participants, I was conscious of my ‘insider’ and ‘outsider’ status. The term ‘insider’ is often used to refer to an individual who holds similar characteristics to research participants while an ‘outsider’ refers to a person who is notably different from their informants (Dowling, 2010). In terms of this research, I straddle the line between insider and outsider. I am an insider because similar to the Filipina caregivers being interviewed, I am female and of Filipino heritage. I can understand the native language and I am connected to the Filipino community. However, being a master’s student and a middle-class Canadian-born citizen who does not have experience working abroad as a live-in caregiver positions me as an outsider.

Dowling (2010) states that being an insider allows the researcher’s collected data and interpretations to be more valid than the data collected and analyzed by an outsider because participants are more likely to talk freely and the researcher is more likely to understand the participant’s perspective. In this study, I felt participants were comfortable when talking to me about their experiences as caregivers because I would talk in Taglish (a mix of Tagalog and English) and talk about my own personal experiences in the Philippines. However, based on my familiarity of the Filipino culture in the early stages of the data collection process, my
acknowledgement of understandings of a topic may have prevented the participant from explaining the topic in more depth and in a way that could be understood by individuals outside of the Filipino community. To correct this limitation, I positioned myself as an outsider (i.e., middle class, Canadian-born, master’s student, no experience as a caregiver) to allow participants to articulate their experiences and feelings more clearly (Dowling, 2010)

Mullings (1999) states that *positional spaces* such as gender, race, class or age influence the level of trust and co-operation between the researcher and research participant. Mullings (1999), discussing her own experiences as a women of British/Jamaican heritage from a North American University, states that by strategically identifying herself as both an insider and outsider she was able to obtain valuable insight from participants. To obtain as much relevant information as possible during the interview, I would spend time conversing with each participant about my own *positional space* prior to the interview. The first topic I would discuss with the research participant was my Filipino heritage. I talked about where my parents were from in the Philippines and that I was born into a middle-class family in Canada. In emphasizing similarities with respect to our cultural upbringing, I attempted to build trust between myself and the research participants. Explaining my reasons for undertaking this research also led to greater trust between myself and the research participants. I would explain to participants that not only did I want to shed light on an important issue but I also wanted to conduct research that would be meaningful and allow me to build stronger ties with the Filipino community. Prior to the interview, I also emphasized that my role as a master’s student and researcher was to provide them with a confidential platform where they could speak about their experiences as a live-in caregiver in Canada.
A total of 21 research participants were interviewed between April 2016 and July 2016. The characteristics of the 21 research participants are presented Table 2. All research participants were women born in the Philippines and immigrated to Canada under the Live-in Caregiver Program. Of the 21 research participants, 15 cared for children, 3 cared for elderly persons, and 3 cared for both children and elderly individuals. None of research participants cared for individuals with special needs. Seventeen of the 21 research participants were former live-in caregivers whose time in Canada ranged from three to thirty-six years. The remaining 4 research participants are current live-in caregivers who have been in Canada for 2 years or less. While the majority of the participants were living-in their place of employment, two research participants stated that they lived-out from their place of employment during their time working under the Live-in Caregiver Program.
Table 2. Characteristics of Research Participants

<table>
<thead>
<tr>
<th>Total Sample</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>2</td>
</tr>
<tr>
<td>30-39</td>
<td>9</td>
</tr>
<tr>
<td>40-49</td>
<td>7</td>
</tr>
<tr>
<td>50-59</td>
<td>2</td>
</tr>
<tr>
<td>60-69</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>2</td>
</tr>
<tr>
<td>Post-Secondary</td>
<td>19</td>
</tr>
<tr>
<td>Country of Origin:</td>
<td></td>
</tr>
<tr>
<td>The Philippines</td>
<td>21</td>
</tr>
<tr>
<td>Years Living in Canada</td>
<td></td>
</tr>
<tr>
<td>0-2</td>
<td>3</td>
</tr>
<tr>
<td>2-10</td>
<td>14</td>
</tr>
<tr>
<td>10-15</td>
<td>2</td>
</tr>
<tr>
<td>15+</td>
<td>2</td>
</tr>
<tr>
<td>Husband/Children Remaining in the Philippines</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immigration Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live-in Caregiver Program</td>
</tr>
<tr>
<td>Caregiver Program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live-In</td>
</tr>
<tr>
<td>Live-Out</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current or Former Live-in Caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current</td>
</tr>
<tr>
<td>Former</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer Relation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
</tr>
<tr>
<td>No Prior Relation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
</tr>
<tr>
<td>Elderly</td>
</tr>
<tr>
<td>Children and Elderly</td>
</tr>
<tr>
<td>Special Needs</td>
</tr>
</tbody>
</table>
The interviews took place in a private location determined by myself and the research participants. The location was based on where the research participant and I felt most comfortable to engage in a relaxed conversation (Valentine, 2005). The length of the interviews ranged from thirty-three minutes to one hour and forty-six minutes, with the average length of the interviews lasting one hour. With consent of the participants, each interview was audio recorded and transcribed verbatim for analysis to allow myself to concentrate on the interview, better engage with the research participant as well as produce a more detailed and accurate analysis of the interview (Valentine, 2005). Words spoken in Tagalog during the interview by the research participant were translated to English in the transcription by myself. Notes were taken during the interview to better direct questions.

Prior to the beginning of data collection, ethical approval was obtained from the University of Toronto’s Social Science, Humanities and Education Research Ethics Boards to ensure confidentiality and privacy as well as minimize risk to the research participants. An information letter outlining the nature and intentions of the research study, the duration and location of the interview, the freedom to withdraw from answering a question or the entire interview without consequence, guaranteed confidentiality and anonymity as well as contact information to NGOs supporting caregivers, the researchers and the Human Research Ethics Program was distributed to each research participant prior to the interview followed by an informed consent to be signed and indicated whether they agreed to having the interview recorded (see Appendix 1 and 2). Questions and concerns presented by the research participants prior to and during the interview process were addressed. Following the interview script (see Appendix 3), a short demographic survey was distributed (see Appendix 4). All participants were given a twenty-five dollar honorarium as well as TTC tokens if they commuted to the interview location.
3.4 Data Analysis

The interview data was analysed based on a grounded theory approach (Strauss and Corbin, 1998; Bryman & Bell, 2016). Grounded theory refers to an approach in which theories emerge from data (Bryman & Bell, 2016). A grounded theory approach was chosen in this research study to utilize coding techniques to generate theory (Bryman & Bell, 2016). Transcribed interviews were initially coded using text-based programs such as Microsoft Word and further analyzed using qualitative data analysis software (e.g. NVivo).

Strauss and Corbin (1998) describe three types of coding to be used when deriving theory from data: open coding, axial coding and selective coding. Open coding refers to the process of examining and categorizing the data while axial coding involves creating connections between the created categories following open coding (Strauss and Corbin, 1998). The third type of coding, selective coding, leads to identifying relationships between categories (Strauss and Corbin, 1998). In this research study, open coding resulted in the categorization of initial themes such as the prevalence of social support networks, work experiences, perceived health status and barriers to accessing health care services. This coding process was followed by axial coding, which involved making connections between the themes identified using open coding (e.g., specific work conditions as a barrier to accessing health services, work conditions affecting perceived health). Finally, selective coding was used to identify core concepts and relating axial codes to it.

3.5 Ensuring Rigour in Qualitative Research

In qualitative research, the work of Baxter and Eyles (1997) is widely cited and used as the basis for establishing rigour. The four criteria for establishing rigour presented by Baxter and Eyles (1997) are credibility, transferability, dependability and confirmability. Credibility refers to the
validity of the interpretations being made by the researcher concerning the population being studied (Baxter and Eyles, 1997). In this study, purposeful sampling (Patton, 2015) was used to identify “information rich cases” (Baxter and Eyles, 1997; Patton, 2015). Information rich cases are those from “which one can learn a great deal about issues of central importance to the purpose of the research” (Patton, 1990 p. 169) When searching for “information rich cases,” participants were recruited at locations where Filipina caregivers gathered (e.g. NGOs supporting Filipina caregivers, churches) as well as through the Filipino newspaper. Baxter and Eyles (1997) state that providing prolonged engagement is another means of enhancing credibility. Prolonged engagement is defined as spending an adequate amount of time with respondents to build trust and rapport (Baxter and Eyles, 1997). I attempted to build trust and rapport with the research participants by providing time to get to know the respondents prior to the interview. Baxter and Eyles (1997) also stress the importance of ensuring data saturation (i.e., referring to the moment when no new themes emerge in the data) is met. In this research, data saturation was achieved with 21 participants in that redundancies were found among multiple participants with no new developing constructs. To establish credibility during the data collection process, bias was reduced by interviewing caregivers with various experiences in Canada (e.g. live-in vs. live out, current vs. former, young vs. old). To establish credibility after data was collected, negative case analysis was used when analysing the data. This refers to the identification and presentation of findings that do not necessarily support the overall findings (Baxter and Eyles, 1997) (see Chapter 4).

The second criteria of ensuring rigour, transferability, refers to the extent to which research findings can be transferred to a similar context (Baxter and Eyles, 1997). While the goal of qualitative research is not generalizability, the idea behind transferability is to provide readers
with adequate in-depth information about the research study including details on methods, participants and analysis.

Dependability, the third criteria proposed by Baxter and Eyles (1997), refers to the extent to which the results of the research study are consistent and reliable. Baxter and Eyles (1997) suggest the use of low-inference descriptors as a way to strengthen a study’s dependability. Low-inference descriptors are defined as tools that allow interpretations to agree with the data collected (Baxter and Eyles, 1997). Therefore, the use of low-inference descriptors such as field notes and audio recordings that were transcribed verbatim and coded consistently were used to reinforce the study’s dependability. Having the same interviewer for all interviews and similarly structured guiding questions throughout the interview were also strategies used to maintain dependability.

Confirmability is the final criteria proposed by Baxter and Eyles (1997) for ensuring rigour in qualitative research. Confirmability emphasizes how the importance of recognizing how the researcher’s interests, biases and motivations affect decision-making throughout the research process, how questions are asked and how collected data is interpreted (Baxter and Eyles, 1997). As mentioned earlier, my own inherent biases as a middle-class, Canadian-born citizen of Filipino heritage plays a role in shaping the research process.

3.6 Conclusion

This chapter outlines why semi-structured interviews were chosen, recruitment methods, the characteristics of the participants, and how data was collected and analysed. This chapter also discusses the work of Baxter and Eyles and how their work was used in attempt to establish rigour and design a solid research study.
Chapter 4

4 Results

4.1 Introduction

This chapter presents the results of twenty-one semi-structured interviews conducted with immigrant Filipino live-in caregivers in the Greater Toronto Area, Ontario. The results are presented in two sections. The first section discusses the participants’ expectations and realities of being a live-in caregiver in Canada. The second section examines the health of immigrant Filipino caregivers and is divided into four subsections sections. The first subsection looks at the overall health of caregivers, perceived changes in health and the ease/difficulty experienced in maintaining health status. The second subsection focuses on how perceptions about work conditions as a caregiver affects health. Perceived barriers to accessing health services is examined in the third subsection. The final subsection focuses on how social support impacts the health of Filipino caregivers. The chapter concludes with a summary of the overall findings.

Throughout the chapter, selected quotes are presented to demonstrate similarities and differences of experiences among immigrant Filipino live-in caregivers. This chapter concludes with a summary of the study’s key findings.

4.2 Migration Expectations

To understand the impact employment as a live-in caregiver has on health, it is important to first understand the caregivers’ motivations and expectations of coming to Canada as well as the resulting realities upon arrival.
4.2.1 Why Canada

At the beginning of each interview, immigrant Filipina caregivers were asked why they decided to work as a live-in caregiver in Canada. A better quality of life was discussed among 16 participants in the research study. Six participants related a better life to being able to be eligible for permanent residency in Canada. Bringing their family to Canada as a way of providing a better life for their families was discussed among 4 caregivers. For example, as one participant states, she decided to come to Canada as a live-in caregiver because the employment opportunity allowed her to become eligible for permanent residency, and it also gives her the chance to bring her family to Canada:

“Well this is for me also to have first like of course most people do like to have a better life, and to bring the kids over here, your family, and you know for them to have a good education, and for me I am just waiting for my PR...” – Participant 1

Another participant discusses how the inability to obtain permanent residency in other countries is what led her to come to Canada:

“But then the, so I decided to go, just because Canada, as they say, they can, you can become a citizen, you and then, you can have what you want, but in Hong Kong you don’t have it. And back home [in the Philippines] there’s no future. So there’s only one way, go forward. And that’s what I did.” – Participant 7

To provide a better life for caregivers’ families in the Philippines, 18 of the 21 participants interviewed said that they financially supported family members by sending remittances during their employment as a live-in caregiver. In this study, 8 of the 21 participants reported leaving their immediate family (e.g., children, husband) in the Philippines during their time of employment under the Live-in Caregiver Program. Only 3 of the 21 participants indicated that they were immigrating to Canada for the sole purpose of providing for themselves.

---

4 PR refers to permanent residency.
In addition to a better life, knowing people settled in Canada is another reason why 6 immigrant Filipina caregivers decided to work as a live-in caregiver in Canada. Nine participants reported that they had family and friends in Canada prior to immigrating to Canada. Of the 9 participants, 3 participants were sponsored to be live-in caregivers by their family members in Canada:

“But my uncle offered me like sponsorship. Because he also needs help with all of my cousins. They are still in school. I think he just got promoted that time, so he is going to spend more time in the office, so he said, he offered it to me, and I said, yea okay. I don’t want to go back to school for now, because I just finished four years [of school].” – Participant 3

Ease of entry into Canada was another reason why 6 out of the 21 participants decided to come to Canada. Participant 20 explains how coming to Canada was much easier than applying for a work visa in the United States:

“Could you imagine in only two and a half months then my visa came [to go to Canada], during that time, that 2010. … That’s just ‘cause it’s faster compared to US. After the twin tower bumping, processing of visa coming to US, by that time, it’s not possible for us anymore. It takes a very long time. And you need to undergo it’s just like telling that, you need to go through the needle, pull, like that, while in Canada it’s open. It only takes 3 months and we’re here. So I said, I had better go to Canada.” – Participant 20

Escaping poor work conditions in other countries is another main reason why two Filipina caregivers immigrated to Canada under the Live-in Caregiver Program. Participant 10 describes how unkind treatment from her employer played a role in her immigrating to Canada:

“Well it’s the easiest way for me to enter Canada. I worked in Hong Kong for like a month - no a year and six months. But at first I don’t have any plans of going here. But then my employer back in Hong Kong was really rude so that – and my sister was here at the time, and she asked her employer if she could sponsor me. So it was faster, so.” – Participant 10
Another participant states how the inability to find employment in the Philippines led her on a path to becoming a caregiver so she could immigrate to Canada under the Live-in Caregiver Program:

“Canada, of course, there’s a lot of opportunity here, compare in the Philippines. For example, like employment, I’m finished my course but then it’s hard to find the job there, in our country. So I decided to study caregiver since my sister is here already, willing to help me. So, so go.” – Participant 6

Additional reasons why immigrant Filipina caregivers chose to immigrate to Canada included a lack of financial stability in the Philippines to pay for health care or for college.

Overall, while the specific reasons why Filipina caregivers come to Canada vary, 16 participants shared a common goal of providing a better life for themselves and their families.

4.3 Employment Expectations

Under the Live-in Caregiver Program, work contracts are established between immigrant caregivers and their employers. Three caregivers’ expectations about employment were based on what they knew about the policies of the Live-in Caregiver Program and the responsibilities outlined in their work contracts. As one participant states, her expectations of being a caregiver in Canada were based on the rules and regulations outlined by Citizenship and Immigration Canada:

“I have, I have all the expectations. Well the expectations is already there. When I heard about the caregiver, when I’m learning about the caregiver, I know. I know there’s rules. I know all the rules that [the caregiver] should do, and then there’s a benefit and there’s a use a lots, there’s lots you need to do like processing a paper before you’re a Canadian. So all of that, I know when I’m studying the live in caregiver program.” – Participant 20

Further, all 21 participants either participated in training to become a caregiver in the Philippines or had experience working as a caregiver in other countries. For example, four participants stated
that they had training as a caregiver when in the Philippines and fourteen participants indicated that they had experience working as a caregiver in other countries (e.g., Philippines, Dubai, Hong Kong, Singapore, Malaysia, and Cyprus). Having both training and experience as a caregiver was reported by 3 participants.

Nine participants discussed expectations related to work experiences. Six participants expected a lighter work load in Canada. As one participant states:

“Well my expectation because it is really different in Hong Kong was like my off and then the like it’s much more lighter work compared to Hong Kong… Yeah. Well in Hong Kong you work your your ass off, like I wake up like 5:00 am and finish around 11-12 pm, 12am I mean. That is a lot of hours, and then if it’s my off, which it was just given one day a week, it’s uh you still have to work before you go out, and then you have to come back.” – Participant 1

Three participants expected that they would earn more money in Canada than the Philippines and Hong Kong. As Participant 6 stated:

“I expect, honestly, I expect more income, so that I can add, the first thing, if I have lots of money, you know, lots of income to help my family, my mother and father, and that ya. That’s the first thing I want, everybody actually.” – Participant 6

Interestingly, eight participants mentioned having no expectations about immigrating to Canada. As one participant states:

“Not really. No. Cause I was 23 by then. So I don’t know. Like I just come here without any – nothing. Like I just came, like I don’t know what’s gunna happen. Ya.” – Participant 15

Additional expectations expressed during the interviews included better treatment from Canadian employers compared to employers of other nationalities, free provincial health care and an overall better quality of life.
Generally, employment expectations among participants were reflective of the rules and regulations of the Live-in Caregiver Program and the contracts established between participants and their employers. Expectations of potential work experiences, being able to bring their family to Canada or participant not having any expectations were also expressed by Filipina live-in caregivers.

4.4 Employment Realities

With an understanding of what immigrant Filipina caregivers were expecting in regards to their employment, this section examines the realities of their employment. These employment realities describe the employment issues experienced by participants interviewed in this research study. Employment issues that participants most frequently mentioned were related to working overtime, completing work outside the contract and a lack of privacy and freedom.

4.4.1 Working Overtime

Citizenship and Immigration Canada does not regulate the number of hours immigrant caregivers are required to complete. The number of hours completed by live-in caregivers is determined by the employer. However, Citizenship and Immigration Canada does stipulate that live-in caregivers are required to complete at least 30 hours a week or 24 months of full-time employment to be eligible to apply for permanent residency. Consequently, a full work day equates to approximately 8 hours a day. While 10 participants indicated that they worked 8 hours a day, 11 participants reported that they had experienced working an excess of 8 hours per day with participants indicating that this happens regularly:

“Most of the employers are like that. Even though it’s in your contract, especially if you are under the program, they didn’t’ follow that one.” – Participant 15
One participant reported that she would babysit every Saturday while another participant stated that she worked 24 hours a day, 7 days a week for her employer:

“Yes actually. But they are not paying me like 24/7... they are not paying it’s only hours during the day as under caregiving program.” – Participant 9

Interestingly, only participants caring for elderly employers reported being on call for 24 hours. In this study, 4 participants cared for elderly employers. Being on call for 24 hours a day may be associated with having to provide around the clock care. As one participant specified:

“Oh for the elderly, I have, I am with her with 24 hours, because you have to watch her sometimes she’s going to the washroom and you don’t want her to fall, or so I have to, I have to be with her 24 hours. But in separate room.” – Participant 8

Of the 11 participants who reported working in excess of 8 hours a day, 9 individuals reported that they did not receive overtime pay:

“Ya, I talk already to them, just last week, just last week. But then they told me that just wait for a month or two months because they are now hard up, they are now hard up for financial hard up. So just wait for my increase.” – Participant 6

Further, 2 of the 11 participants who reported working in excess of 8 hours a day were employed by family members. The two participants indicated that their familial relationship made them feel obligated to work more than 8 hours:

“I am not comfortable leaving the house without doing anything like helping out with chores. I won’t feel comfortable like just like leaving them with like the dishes. I have to wake up early to help out than just to leave it. If I was living in like with a regular employer, like not my relatives, I can just leave right. I won’t care, because I don’t know them and I am not working, they are not paying me that time, but since they are related to me, like well.” – Participant 3

“Especially when you are here, especially in my relatives here. I feel so obligated, and they will, essentially push you to that, that you are here because of [them]. So sometimes I feel like, is it really good to help your family or your relatives to go here, and then push you over? Because they helped you, they want you to do this kinds of things and stuff, because they help you... But as much as I can say,
anything regarding to relative getting the caregiver here. I am not really sure if that is good.” – Participant 5

Lastly, another participant mentioned that she did not want to ask for her entitled overtime pay:

“Ya, it’s like, it’s my off, supposed to be 4 o’clock in the afternoon, but they, they’re coming home six o’clock. So it’s I can say, in a week, they’re doing that three or four times a week. So, I’m not demanding for, I don’t want to demand for the overtime pay because I’m already, I’m just living downstairs.” – Participant 8

In addition to working overtime, participants reported other violations to their work contracts.

4.4.2 Working Outside the Contract

Similar to the scheduling of hours, employers are responsible for supplying Citizenship and Immigration Canada with a description of the duties for foreign live-in caregivers. Generally, tasks completed by live-in caregivers involved caring for children, caring for elderly individuals and/or the completion of household chores. However, 9 caregivers reported that they had completed work not outlined in their contract. Reported work completed that was not specified in the contract includes cleaning outside of the home, walking dogs, groceries, ironing, gardening and working at the employer’s family gatherings. Interestingly, one participant discussed the vagueness used in the description of their duties:

“Um, it’s just written there, it’s just light household, so I don’t know what is light … No. It didn’t, they didn’t specify what those light household chores.” – Participant 8

Such contract violations place caregivers in a position of vulnerability. Filipina live-in caregivers are reliant on their employer to demonstrate to Citizenship and Immigration Canada that they have completed the tasks described to be eligible for permanent residency. If tasks undocumented in the contract are requested by the employer and are refused, the caregiver may be replaced with someone who will complete the work. One caregiver reported feeling obligated
to complete any job asked of them in order to not jeopardize their changes of permanent residency:

“Like for example, cleaning the car is not in the contract. Cleaning the car in the snow is not in the contract. Cleaning the garage is not in contract – and there’s a lot of more, there’s a lot of work in Oakville that’s not in the contract. But still, its ok. … Recreational vehicle. That’s why RV. They bought that, the Oakville family. They go, one summer, they go outside, just like everything, everything they need in the RV, from house to RV, me. Oh! Ya, until and then they go, go whenever they want. And then they go back. And everything from RV everything they used in that RV will go back in the house. So, oh. It’s not in the contract. But then it’s ok, because of my paper, because of my open permit paper, Oh, it’s ok.”
– Participant 6

Among the 3 participants who were employed by family members, 2 participants discussed completing work not indicated in their work contract:

“…since I am technically living in their house, so there are loop holes like for the one I mentioned, right it is dinner time, they eat and I just clean it up. Even that is not my job right. Technically I am off work. I should just be, just be upstairs eating whenever I want, but since we are a family, I have to eat whenever they eat, and I have to clean it up. So and also it is harder to voice out, because they are family. Not like when you have like a regular boss, you can say, you can lay out your concerns, right. This is not right. This is blah blah blah, blah blah blah, but since they are family, it is harder I think”
– Participant 3

One of the 3 participants employed by their family indicated that she did not know her family arranged for her to work for another employer upon arrival:

“Because you thought you already know your relatives, right. They are so nice and such things, but then again, I don’t really know that I will be working in a different employer at that time, but when my ticket is already there, that is the only time that they mentioned, oh you will be working, we already hire, found an employer for you. We just saw, you need to work for them and you can live in there and stuff like that.”
– Participant 5

4.4.3 Privacy

Previous research has shown that live-in caregivers experience a violation of privacy, and exploitation from working overtime hours without pay and from performing tasks not stipulated
in work contracts (Atanackovic & Bourgeault, 2014; Hodge, 2006; Pratt, 1997; Stiell & England, 1997). The interviews in this study included questions about privacy and freedom to understand whether live-in caregivers today continue to experience violations of privacy and exploitative work conditions.

According to Citizenship and Immigration Canada (2011), employers of live-in caregivers are required to provide them with a private space such as room with a lock. Nineteen of the participants indicated that they did have a room to themselves. Despite having a room of their own, five of the participants reported occasions when they did not feel like they had enough privacy. Two participants reported not having a lock on their room. Other explanations suggested to be an incidence of a lack of privacy by participants included having the internet blocked and not having a separate entrance:

“First in the contract it says there that my room had a lock, but it doesn’t have. Uhm, what else? I think that is it, and I don’t remember everything, but that is what struck me, because I read it. I read the employment contract, and it says there like this is my room. I have my own space, and it has a lock…When I am changing clothes, I am locking the door, right. Sometimes my cousins walk in my room, like and I am just like on my computer, but what if I was changing, right that would be a violation to my privacy. I think of that.” – Participant 3

In one of the most extreme cases, one participant reported that she had been living with at least two employers during the time she worked as a live-in caregiver. This participant was legally contracted to work with one family to whom she was related. However, this family could not afford to hire her as a full-time live-in caregiver so during the week days she was sent to another family to work. At this second location, she was forced to share a room with the elderly woman for whom she was caring. When living-in with her relatives on weekends, she still lacked privacy as she shared a room with her grandmother:
“But it is the same thing in Pickering. I am still in the same room as my Lola, but in Ajax she is not watching like my Lola, so it is fine, and they treat me as a family, so it is fine, even if I am not, don’t really have my own privacy, like technically speaking my own room, I don’t have that, but I can do whatever I want. I can call my family. I will just be on the other side of, there will be room for talking to them privately, and stuff like that, and also here when it comes to the room, I am using the computer room, so it is not really a privacy still, but I have my own bed, so that is okay. … No. I don’t have my room there, and I am sharing it with my Lola, so whenever I want to rest, I have to, well I still have to watch TV, because she needs to watch it, because it is really loud, even if you don’t want to watch.” – Participant 5

In total, 2 of the 3 participants who were employed by their family reported a lack of privacy.

### 4.4.4 Freedom

In addition to working overtime hours and completing duties not stipulated in their work contracts, the interviews revealed that general feelings of obligation may impact Filipina live-in caregivers’ freedom.

While most participants reported a sense of freedom to do what they like on their time off, 6 out of the 21 participants reported restrictions. Three participants described how caring for an elderly person did not allow them to have the freedom to come and go as they pleased because they had to be on call for 24 hours:

“No, because in this case now I can’t even go to the grocery, just to buy anything, especially we are going to be alone, because the one that I am taking care of now is, you can’t really leave her, because she has Alzheimer’s, the first stage, and she goes to the washroom every now and again. Yea she has cancer, so as much as you can give comfort to her, you will give it, right. So I will, because we have this monitor, baby monitor, so whenever I go, even if just in the basement, I have to have it, because I need to watch over her.” – Participant 5

“The come and go it’s not, because of the lady’s hundred and three, and she couldn’t, that’s the only thing, because after, supposed to be in the program after your time, you can go. You can do what you want, but that time I can’t. because um it’s like I’m having, I’m tied up with them. And that’s the only thing that I don’t have when I’m staying with them. I don’t have the time to go out, even
though I want to go or meet somebody in time of emergency back home, I can’t do it, so I cannot leave the old lady.” – Participant 9

“Oh I cannot going out – just wait with them there because elderly you cannot just leave them, right? You have to stay there 24 hours because I took care in the elderly has dementia. So you cannot just leave, even though you like to go anywhere, but you always be there.” – Participant 16

Other participants indicated that they felt restricted by what was available in the area (e.g., all residential with no malls), being criticized by their family for wanting to spend time with others and the unavailability of employers who were parents of children.

To have a better understanding of the role living-in their place of employment had on Filipina caregivers, participants were asked to discuss the benefits and drawbacks of living in as opposed to living out. The most frequently reported benefit of living-in is the ability to save money (e.g., less costly for rent, food or transportation to go to work). The benefit of being able to save while living-in was described by 18 participants.

“The good thing in live in, is you can save more money, right? like you cannot always going out and pay your fare every time you’re going out. Then it’s not, when you go out, it always happen that you’re gunna go to a mall or you’re gunna go somewhere and then you have to spend money. When you’re as a live in, you can just stay home and then you’re free, your free food, you’re not the one who buy. You didn’t need to buy your food, because the employer the one who buy.” – Participant 16

With respect to the challenges of living-in, 14 participants reported that they did not have enough time for themselves for activities such as seeing friends and family. Being taken advantage of with respect to working overtime without pay was the second most common challenge to living-in the place of employment (n=6). Other challenges of living in included being unable to work a part-time job (n=3) and boredom (n=1).

4.5 Health Status of Immigrant Filipina Caregivers

This section examines the health experiences of immigrant Filipina live-in caregivers.
4.5.1 Overall Health and Changes and Maintenance of Health Status

When asked, 14 of the 21 participants reported good overall physical and mental health. Participants’ perception of health status was a reflection of their health in comparison to the Philippine-born population and not the Canadian-born population. When asked if they felt their health had changed since migrating to Canada, nine participants reported their health had remained stable, nine participants reported a decline in health status, and three reported that their health had improved. A decline in health was explained to be the result of allergies, feeling stressed and depressed, aging, being diagnosed with medical conditions (e.g., cardiomyopathy heart disease, autoimmune disease), frequent illness, migraines, high blood pressure, lack of exercise and the change in climate:

“Because my migraine got worse at that time. First few months to a year, because those are the type that my relatives are pushing me, those kind of stuff and then of course the allergy came in, which is now getting much better in a way, and yea that is it.” – Participant 5

“During the program, I really had a little bit, a problem with that heart beating, chest pain. But then, now I’m not already in that program, I’m more ok now, because I have the exercise now as I said before, I have the walking, keep moving all the time, it’s more energy consuming now because of my kids” – Participant 9

Three live-in caregivers reported that their health had improved since immigrating to Canada because they no longer experienced migraines and experienced improved work conditions in contrast to work experiences in other countries such as Hong Kong and Jeddah:

“When I came to Canada is more better… Because here at least here, not unlike the other country that I was working before, is there different like the employer is treating you as a slave. And then you know there’s emotion there, there’s stress or something like that, you know? but when you, when I came here, it’s more better. It’s more better, it’s not, I’m not too stress, although sometimes, that’s a part of a job, part of a job some time that you are stressed. Ya. But not always, not, like in Hong Kong, not unlike in Jeddah, that every day, like oh my gosh, I just want to go home.” – Participant 16
4.5.2 Employment and Health

This section examines how work conditions as a live-in caregiver are perceived to impact the health of caregivers. Specifically, caregivers were asked how living-in with their employer affected their physical and mental health and well-being in a positive or negative manner. Although 7 participants stated that living in as a caregiver with their employer did not affect their health, 14 participants reported that their physical and mental health was in some way affected by them being a live-in caregiver.

Employment and Physical Health

When discussing the impact of work on health, 10 participants reported that working as a live-in caregiver had negatives effects on their physical health. In particular, caregivers reported a change in diet, an increasing sedentary lifestyle and exposure to the work environment.

A lack of exercise was the key contributor in affecting participants’ physical health in a negative way (n=3):

“You know what, I don’t have any exercise anymore that time. So um, so it’s just only we’re just staying in the house, sitting on the porch, walking around the house, something like that. It’s not really my routine. You know what, in my age that time, I want you know, I want something like walking outside and doing some energetic things, something like that. I can’t do it. So that time I have, I have problem with my health like, I have a hard time move, I have a constipation all the time, because I don’t have exercise and then actually I don’t have exercise and I have a palpitation of my heart that time.” – Participant 9

Secondly, being a live-in caregiver, participants shared the same diet as their employers. Two participants suggested that the change in diet affected their health negatively. One participant stated adapting to a diet accustomed to Jewish people did not make her feel healthy:

“Especially now, because in Jewish people they don’t really eat rice, right, and now in Pessa’h, they can’t eat at least bread or any flour, related stuff. So I feel...”
like sometimes I am not eating right, because that is their menu. That is how they eat, so I have to adjust for them. They won’t adjust for me, because it is also religion related thing.” – Participant 5

Third, exposure to the work environment negatively affected the health of two Filipina live-in caregivers. For example, one participant felt that her employer’s smoking negatively impacted her physical health. In addition to employer’s habits, the illnesses individuals brought into the home negatively affected the health of one Filipina caregiver:

“My cousins go to school, right, and they get viruses there. They get sick there. They come home, and I take care of them, like physical contact, and so what they get, I get too, right, and if they are sick, they will be at home, staying at home, and I am sick too.” – Participant 3

Other perceived contributors observed to negatively affect immigrant Filipina caregivers’ physical health included a physical strain involved in caring for the elderly, as well as feeling physically weak and not being able to eat or sleep as a result of being away from family in the Philippines.

Contrastingly, only one live-in caregiver reported that working as a live-in caregiver had a positive effect on their physical health. A healthy diet influenced by her health conscious employers was perceived to be the reasoning for such positive physical health.

Employment and Mental Health

In addition to perceived impacts on physical health, participants reported impacts to their mental health and well-being. Among the 13 participants who discussed factors affecting mental health, all 13 caregivers suggested that being a live-in caregiver negatively affected their mental health as the participants described feelings of depression, sadness, homesickness, stress and anxiety. Two key stressors affecting mental health were related to family separation and work related stress.
Under the Live-in Caregiver Program, participants depart the Philippines and leave behind all their family and friends in the Philippines. Separation from family and friends in the Philippines was reported to negatively impact mental health due to an increase in homesickness and sadness by 8 participants. One participant described how her feelings of homesickness were especially prevalent in her first months residing in Canada:

“Because during my first months here, my homesickness is really bad, and I believe it adds on from the stress that I took from my relatives here right, so both of them together is really bad. I think that is where the time that almost every day I have my migraine because of that, because even if I am just doing something, the homesickness, I feel like, oh I need my mom. I need my sister. It is really tiring. I want to go home now, but you still need to hold onto it” – Participant 5

Work related stress from caring for children (n=5), the elderly (n=1) or both (n=1) was the second most common factor perceived to negatively impact Filipina caregiver’s mental health among 7 participants. For example, one participant found caring for a child with attention deficit hyperactivity disorder (ADHD) stressful because she had no prior experience caring for a child with such a condition:

“But during my first time, because it’s a transition period, that I needed to learn his attitude, I’m always furious and then getting mad that I said I want to go out, I will leave you, it’s because of his attitude. Those were only the times that makes me hard. Living with those kids.” – Participant 20

Another participant described how she was sleep deprived due to the stress of feeling responsible for her elderly employer:

“then I want to sleep but because I cannot sleep because I’m thinking the old lady how – because I’m thinking I’m gonna sleep then if there’s something happening the old lady it’s my responsible, it’s my responsibility” – Participant 16

Lastly, two participants expressed feelings of depression as a result of caring for other children that were not their own which led to a perception of negatively impacted health. One participant states,
“Because there would be times that you would be depressed. … I cried a lot like I could take care of other kids, but I could not take care of my kids.” – Participant 1

4.5.3 Social Support and health

Findings within the literature suggest that social support can be protective for health (Reblin and Uchino, 2008; Segrin & Passalacqua, 2010; Uchino, 2006; Zaleska, Brabcova & Vackova, 2014). Although being a live-in caregiver may suggest that caregivers are socially isolated due to the live-in condition, all 21 participants within this study demonstrated that they had strong social support networks prior to and during their time as a live-in caregiver in Canada. Primary social support networks were identified as family and friends (mostly other caregivers) in Canada and the Philippines.

To assess the importance of social networks in Canada, participants were asked whether it was important to know people prior to immigrating to Canada. Ten participants responded that they felt it was important to have networks in Canada before emigrating from the Philippines. The most common reason why social networks prior to immigrating to Canada was viewed as important was related to participants having someone they could learn from during the adjustment period to a new environment. As one participant states:

“So ya it’s important like if you know someone here, it’s important. Cause like if you feel like homesick and then like if you adjust on the surroundings, if you adjust to your environment, it’s better if you know someone that can – what do you call that – comfort you, like during the time, especially when you’re first six months” – Participant 15

In fact, when it came to identifying who participants felt most comfortable speaking to when they needed to talk, needing advice about problems related to life in Canada, or advice about being a caregiver in Canada, friends who were current or former caregivers in Canada were the top persons of choice:
“Oh ya. In the weekend I can talk to them and I can of course if you are new in a place you always needs those people that like want something to talk with you like that. So I’ll try maybe to find some people that I can talk with, I can learn from them I can like, so how can I deal with this if in case also of my kids, of these kids that I take care of. How can I manage them, like that’s why I talk to other people, to those people that, whom I know that came here. So.” – Participant 17

Another reason why participants found social networks prior to immigrating to Canada important included being afraid to move abroad for work in Canada.

### 4.6 Accessibility to Health Care Services

Thus far, this research has focused on the impact work conditions have on physical and mental health. As discussed in Chapter 2, literature on health status among immigrants has linked declines in health status with barriers to accessing health services (Ahmad et al., 2004a; 2004b; Asanin Dean & Wilson, 2008; 2010; Elliott & Gillie, 1998; Jafari, Baharlou & Mathias, 2010; Lai & Chau, 2007; Sutton et al., 2007). In trying to understand this link within this population, participants were asked how work conditions impacted access to health care services. Seventeen participants reported that being a live-in caregiver in some way facilitated access to health care services. The main way being a live-in caregiver facilitated access to health care was the ease of being able to take a leave of absence and living in close proximity to the family doctor. Despite these factors facilitating access to care, perceived barriers were also discussed. Ten participants reported perceived barriers to accessing health services include transportation, a lack of third-party health insurance, difficulties scheduling time off of work, and fear of losing employment.

The ease in being able to take a leave of absence to access health services is the main factor 13 live-in caregivers’ felt facilitated access health services. As one participant states:

“No because that time, if I said to my employer that I have an appointment, they will let me go. They will bring me even to go there. They will drive me ya.” – Participant 17
The second most common way in which being a live-in caregiver facilitated access to health care services was related to the close proximity from the employer’s/weekend home to the family doctor. Eight participants suggested that the faster and more accessible the family doctor is, the easier it is for live-in caregivers to access health care services. As one participant states:

“Cause it’s just, just like, ten minutes from the house. Very accessible.” – Participant 13

However, although close proximity was seen to facilitate access to health care services, the far distance between a family doctor and where the live-in caregiver was residing (during the weekday or weekend) was also seen to be the main barrier to accessing health care services among Filipina caregivers.

The most prevalent barrier to accessing health services among Filipina caregivers was transportation. The distance and cost associated with travel to see a family doctor as well as an inability to navigate around the Greater Toronto Area were factors that made it difficult for Filipina caregivers to access health services. As one participant states:

“And one time I went there, I had the stomach flu, right. I went on the weekend, but my aunt, my uncle, my uncle is the only one who drives in our family. My uncle went out, and I didn’t feel comfortable asking him for a ride, going to the doctor, even if I was like burning with fever the night before and my tummy still hurts, like I walked, I took the bus, like I took three buses just to take there. Yea. … I had to like, I had to do this or else I am going to die from dehydration. So I had to, like summon all my energy… Last month I was just in bed for ten days with the flu, but I didn’t seek like any medical attention, and also yea I remember like three weeks ago, I think I had a urinary tract infection and I passed a out blood and it is very painful…Like I didn’t seek any medical attention. I know that I haven’t, I have UTI, I know but maybe I am just stubborn, and maybe because I think it is far because I am, because as I was saying, after two days and it is still

5 The weekend home is defined as where Filipina live-in caregivers spent their weekends. Filipina caregivers rented a space where they would reside on their days off (typically the weekend).
like, there is something, I’m going to go see a doctor, but then it stopped. But ever since, I didn’t go for a check up” – Participant 3

Difficulties scheduling time to see a family doctor is a second barrier which prevented caregivers from accessing health care services. For example, the hours spent caring for the elderly and children prevented participants from accessing health services:

“But it is weird. For me it is weird. I have a weird schedule. … because it is 8:00 am to 10:00 pm, right. So it is kind of hard [to see the doctor]” – Participant 5

“And maybe when you put it like, when the kids are sick, for example they were sick, and then it is a week day, right, you can’t just really go as you please. You have to see if the kids are going to be there, or will you make it home in time for the kids” – Participant 3

A third barrier to accessing health services was related to not having third party health insurance during the first three months of employment. Similar to other newcomer populations, Filipina live-in caregivers who migrate to Ontario must wait three-months before they are able to access the Ontario Health Insurance Program. Most newcomers are advised to purchase private health insurance during this three-month wait. However, unlike other newcomers, the Live-in Caregiver Program stipulates that employers are responsible for providing third party health insurance for their workers during their first three months living in Ontario. However, only five participants reported that their employers provided third party health insurance. Interestingly, 12 of the participants themselves reported that they did not know that employers were responsible for providing private insurance. This places caregivers in a vulnerable position. As one participant indicated, the lack of private health insurance may exacerbate the stress experienced from moving to a new country:

“I have to wait for my OHIP. So I’m so scared to go out beause sometimes maybe you know I got hit by the car, something like that, accident.” – Participant 11
One participant indicated that not being eligible for OHIP upon arrival led to her to not seeing a family doctor:

“Yea, because of course I didn’t go. You know if you get sick, I guess I didn’t go because you know you need to pay. So leave it. Didn’t see the doctor. Just take some over the counter meds.” – Participant 2

A fourth barrier to accessing health services is related to the fear of losing employment. One participant stated that she did not share her illness with her employer because she feared she would be seen as not fit to care for her employer; thus, resulting in her not receiving care:

“And then they gunna think the caregiver is not good for, not good health to take good care of [Elderly client’s name], so I just take good care of myself.” – Participant 6

4.7 Summary

This chapter presented the results of the twenty-one semi-structured interviews with immigrant Filipina caregivers in the Greater Toronto Area, Ontario. Discussion about Filipina caregivers’ employment expectations and realities first created a framework in understanding how physical and mental health was impacted by caregivers’ work conditions.

The results from the twenty-one interviews demonstrate that immigrant Filipina live-in caregivers immigrated to Canada because they wanted a better quality of life, already knew people in Canada and found it to be a country which they could easily migrate to. In regards to the participants’ employment expectations, participants’ expectations were based on the rules and regulations set out by Citizenship and Immigration Canada as well as the work contracts created by their employers. However, the employment realities experienced by the participants demonstrated that many were forced to work overtime hours, complete work outside the work contract, and a lack of privacy and freedom.
In terms of health status among the immigrant Filipina live-in caregivers who participated in this study, physical and mental health was found to be overall negatively affected. Ten participants reported that their physical health had been negatively by being a live-in caregiver. Negative impacts to physical health included a lack of exercise, poor diet, exposure to the environment and physical strain. Thirteen participants discussed how being a live-in caregiver negatively impacted their mental health. Negative impacts to mental health included family separation and work related stress. All participants demonstrated that they had some form of social support through either friends and/or family in Canada and/or in the Philippines.

Seventeen participants suggested that aspects of being a live-in caregiver facilitated access to health care services. These features of being a live-in caregiver which facilitated the participants’ access to health care services included, the ease of being able to take time off and where the employer and/or weekend home was located. Ten participants stated barriers to accessing health care services. Barriers to accessing health care services included transportation, scheduling, a lack of third-party health insurance and fear of losing employment.

With the presence of negative impacts on physical and mental health as well as numerous barriers to health care services, it is vital that steps be taken to improve the health and well-being of immigrant Filipina live-in caregivers.

The following chapter will discuss limitations, key contributions, policy recommendations and the final conclusion.
Chapter 5

5 Discussion, Recommendations and Conclusion

5.1 Summary of Key Findings

The objectives of this research study were to: i) examine live-in caregivers’ work experiences in Canada; ii) to investigate the relationship between employment as a live-in caregiver and health; iii) to examine how employment as a live-in caregiver affects access to health care; and iv) to investigate how social support impacts the health and well-being of Filipina caregivers.

Using semi-structured interviews with 21 immigrant Filipina live-in caregivers in the Greater Toronto Area, Ontario, the research revealed a number of key findings. First, participants’ work expectations did not always match their employment realities. Specifically, caregivers reported working over time with no extra pay, completing work outside their contract, lacking privacy and restricted within the home of their employer.

Second, participants’ perceived a clear link between their employment conditions and health. Participants reported a change in diet, an increasing sedentary lifestyle and negative exposure from their work environment (e.g., smoking employer, sick children). In addition, participants described how being a live-in caregiver negatively affected mental health due to the stress of being away from their family or work related stress.

Third, the research showed that working as a live-in caregiver can both facilitate and inhibit access to health care services. Seventeen participants reported that being a live-in caregiver in some way facilitated access to health care including the ease of being able to take a leave of absence and living in close proximity to the family doctor. Ten participants perceived
barriers to accessing health care services including transportation, a lack of third-party health insurance, difficulties scheduling time off work and a fear or losing employment.

Finally, immigrant Filipina participants reported good levels of social support with friends and family in Canada and/or the Philippines. Ten participants discussed that the importance of knowing people prior to immigrating to Canada. Further, current or former caregivers were the top person of choice for participants to talk to when they need to express themselves, needed advice about problems related to life in Canada or advice about being a caregiver in Canada. Before discussing the main contributions of the research, some limitations need to be discussed.

5.2 Limitations and Areas of Future Research
First, with respect to the participants, most were caring for children or the elderly and none were caring for individuals with special needs. It is possible that live-in caregivers who are responsible for caring for others with special needs may have different employment experiences, which in turn may have differential impacts on health and access to care.

Second, most of the participants were recruited through snowball sampling and only a very small number were recruited through the Workers’ Action Centre, the Metropolitan Bible Baptist Church and the Philippine Reporter newspaper. Despite the use of a broad multi-pronged strategy for recruitment, this research study demonstrates the importance of snowball sampling for recruiting Filipina caregivers. Snowball sampling may have been the most effective recruitment strategy because it meant that individuals were recruited through existing trusted social networks. It is possible that potential participants did not respond to the newspaper ad or posters placed in Workers’ Action Centre and the Metropolitan Bible Baptist Church because they were not familiar with the researcher and the research intentions. As such, individual
reluctance to participate through those recruitment methods may be a result of fear and lack of trust. As demonstrated in this research, Filipina caregivers are a vulnerable group and may have feared employers discovering they participated in the research and/or said negative things with respect to employment experiences. Therefore, other researchers who wish to conduct research with this population will want to consider using a snowball sampling approach because it was shown to build on existing trusted networks and may facilitate the establishment of trust between the researcher and participants.

It is important to note that the research may not have accessed those caregivers who are more isolated (i.e., not strongly linked to Filipina organizations or other caregivers in the GTA). The employment and health experiences of more socially isolated Filipina caregivers may be unique as compared to those who are better connected and this population therefore represents an important group for future research.

As discussed in Chapters 1 changes to the Live-in Caregiver program in 2014 resulted in the removal of the live-in requirement. The Caregiver Program stipulates that caregivers are no longer required to live-in their place of employment; however, jobs may require caregivers to live in when necessary. In light of the new changes to the Caregiver Program, an initial objective of this research study was to examine whether living-in or living-out(side) caregivers’ place of employment influenced caregivers’ working conditions. While the research sought to identify individuals living out of their place of employment, none were recruited for the research. It is possible that there are distinct differences with respect to the impact of living-in and living-out on health status and access to health care services. However, given how recently the change was made, there may be very low numbers of Filipina caregivers who live out(side) their place of employment. As such, this represents an important group for future research.
5.3 Theoretical Contributions

Even with the above stated limitations in mind, this research study contributes important findings to the large body of literature on immigration and health, the little research on temporary foreign workers in Canada and health, and the lack of research on live-in caregivers in Canada.

5.3.1 Immigration and Health

The findings of the study provide a key contribution to the large body on immigration and health. This study is one of the first to examine the health and well-being of an understudied population, immigrant Filipina live-in caregivers. The literature on immigration and health is mainly quantitative and relies on national survey data with a focus on the general immigrant population with no distinction between different groups of immigrants (Aglipay, Colman, Chen, 2013; Alegria et al., 2008; Ali, 2002; Anson, 2004; Arias et al., 2010; Beiser & Hou, 2014; Betancourt & Roberts, 2010; Borrell & Lancet, 2012; Breslau et al., 2009; Chen et al., 1996; Choi (2012); Cook et al., 2009; Gadd, Johansson, Sundquist, & Wandell, 2006; McDonald & Kennedy, 2004; Menezes, Georgiades & Boyle, 2011; Newbold, 2006; Ng, 2011; Omariba, Ng & Vissandjee, 2014; Puyat, 2013; Schaffer et al., 2009; Setia et al., 2012; Singh & Siahpush, 2001; Stafford, Newbold & Ross, 2011; Wu & Schimmele, 2005). Additionally, a growing body of qualitative research has begun to examine immigration and health for specific subgroups of the immigrant population (Ahmad et al., 2004a; 2004b; Asanin Dean & Wilson, 2008; 2010; Elliott & Gillie, 1998; Jafari, Baharlou & Mathias, 2010.

The number of immigrant Filipina live-in caregivers has been increasing over the past 25 years. From just over 2,000 live-in caregivers in 1992, 23,174 foreign live-in caregivers obtained work permits in 2014 with approximately 90 percent being women originating from the
Philippines (CIC, 2016b; Kelly et al., 2011). Interestingly, the health and well-being of the immigrant Filipina live-in caregiver population has not been studied. Therefore, with the substantial growth of immigrant Filipina live-in caregivers and the lack of knowledge regarding health about this immigrant population suggests that they are an important population to study.

The large body of quantitative research has demonstrated the existence of a ‘healthy immigrant effect’ where recent immigrants are seen as having superior health (e.g., lower rates of mortality, lower prevalence of chronic conditions and mental illness) in comparison to the native-born population; however, the health advantage among immigrants decreases over time to a level similar to or lower than the native-born population (Alegria et al., 2008; Ali, 2002; Anson, 2004; Arias et al., 2010; Betancourt & Roberts, 2010; Borrell & Lancet, 2012; Breslau et al., 2009; Chen et al., 1996; Cook et al., 2009; Deboosere & Gadeyne, 2005; Gadd et al., 2006; McDonald & Kennedy, 2004; Menezes, Georgiades & Boyle, 2011; Newbold, 2006; Ng, 2011; Omariba, Ng & Vissandjee, 2014; Palloni & Arias, 2004; Puyat, 2013; Schaffer et al., 2009; Setia et al., 2012; Singh & Siahpush, 2001; Stafford, Newbold & Ross, 2011). A number of studies suggest that acculturation, whereby immigrants adopt unhealthy and risky behaviours such as poor dietary habits, an increase in alcohol consumption, tobacco use and sedentary behaviours, plays a role in declining health among immigrant populations (Akresh, 2007; Castro et al., 2012; Gilbert & Khokhar, 2008; Hahm, Lahiff, & Guterman, 2004; McDonald & Kennedy, 2004; 2005; Murillo et al., 2015; Setia et al., 2009). In this research study, 9 participants reported a decline in health status. Reasons for a decline in health were related to allergies, feeling stressed and depressed, aging, being diagnosed with medical conditions, frequent illness, migraines, high blood pressure, lack of exercise and the change in climate. While only an increasing sedentary lifestyle suggests acculturation to be a reason for declining health, when participants were asked how being a live-in caregiver affected their physical health,
10 participants reported a negative impact on physical health due to a change in diet, an increasing sedentary lifestyle and exposure to the work environment. Therefore, these three explanations demonstrated how acculturation plays a role in declining health among the participants in Canada. In regards to healthy immigrant effect, this research study provides mixed evidence as an equal number of participants (n=9) report that their health remained stable since immigrating to Canada and 2 participants perceive improvement in health status.

The qualitative literature on immigration and health has also examined barriers to accessing health care services among immigrant populations in Canada (Ahmad et al., 2004a; 2004b; Asanin Dean & Wilson, 2008; 2010; Elliott & Gillie, 1998; Jafari, Baharlou & Mathias, 2010; Lai & Chau, 2007; Sutton et al., 2007). Barriers to accessing health care services included difficulties finding a doctor, language issues and culturally inappropriate medical treatment, the cost of receiving health services, long wait times, a lack of quality care, a lack of familiarity with the health care system, a loss of social networks, transportation barriers (Ahmad et al., 2004a; 2004b; Asanin Dean & Wilson, 2008; 2010; Elliott & Gillie, 1998; Jafari, Baharlou & Mathias, 2010; Lai & Chau, 2007; Sutton et al., 2007). In this research study, similar obstacles to accessing health care services were the transportation barrier and the cost of receiving health services before being eligible for OHIP. Barriers not found in the literature cited were difficulties scheduling a doctor and a fear of losing employment.

5.3.2 Employment as a Temporary Foreign Worker and Health

The sparse literature on immigration and health in Canada that does focus on the subgroup of temporary foreign workers focuses on seasonal agricultural workers (Hanley et al., 2014; Hennebry, 2010; McLaughlin, Hennebry & Haines, 2014; Narushima, McLaughlin, Barrett-Greene, 2015; Preibisch & Otero, 2014; Salami, Meharali, & Salami, 2015). This study provides
a key contribution to the literature in that it provides a novel perspective of another group of temporary foreign workers.

This research study found that physical health was negatively impacted from being employed as a live-in caregiver due to a lack of exercise, poor diet, exposure to the work environment and physical strain. Being a live-in caregiver also had a negative impact on mental health due to long durations of family separation and work related stress. The literature on the health of seasonal agricultural workers also found that poor housing and unsafe work conditions led to physical illness and injury (Preibish and Otero, 2014). This research provides novel insight in regards to other factors which impact physical and mental health. This study demonstrates how poor diet and long durations of family separation can negatively affect physical and mental health respectively.

Research on seasonal agricultural workers have demonstrated barriers to accessing health care services including language barriers, transportation barriers, professionals refusing to accept uninsured individuals, the high cost of services, the lack of knowledge about where to receive care and Canada/Ontario’s health care system, difficulties acquiring time off, discrimination and a fear of deportation (Hanley et al., 2014; Hennebry, 2010; Narushima, McLaughlin and Barrett-Green, 2015; Preibish & Otero, 2014). The findings of this research study show similar barriers including transportation barriers, difficulties scheduling time off and fear of losing employment. However, the finding that most employers do not provide private health insurance is novel to this immigrant group of temporary foreign workers. As discussed in Chapter 4, temporary foreign workers, including live-in caregivers, are to be provided with third party health insurance at the expense of their employers. Sixteen of the 21 participants were not provided with third party health insurance. This research study contributes to the literature in demonstrating a breach in
contract between employer and temporary foreign worker in regards to the third-party health insurance requirement.

5.3.3 Immigrant Filipina Live-in Caregivers in Canada

Research examining the health of Filipinas has predominantly looked at how working abroad in Hong Kong and Israel as a live-in caregiver has negatively impacted their physical and mental health (Ayalon, 2012; Ayalon & Shiovitz-Ezra, 2010; Bagley, Madrid & Bolitho, 1997; Holroyd, Molassiotis, & Taylor-Pilliae, 2001; Margallo & Peligro, 2014; van der Ham et al., 2014). This research study contributes to the established literature on Filipina live-in caregivers in that it is the first to examine how being a live-in caregiver in Canada may negatively affect their physical and mental health. This study shows that being a live-in caregiver may impact health negatively. Ten of the 21 participants reported that their physical health was negatively impacted being a live in caregiver. Thirteen out of the 21 participants discussed that their mental health had been negatively affected.

Lastly, while the work of Pratt (1997; 2004; 2009) does focus on immigrant Filipina live-in caregivers in Canada, her work unveils how the Live-in Caregiver Program reinforces gendered and racial exploitation work conditions and the impact family separation has on the lives of caregivers and their families. This research contributes to the literature by observing how work conditions and family separation can impact the physical and mental health of immigrant Filipina live-in caregivers.

5.4 Policy Recommendations

The results of this research study demonstrated clear violation of immigrant Filipina caregivers’ rights with respect to their work contracts. Caregivers reported numerous violations to their contract including hours of employment, completing tasks not indicated in the work contract, and
a lack of privacy and freedom. Work contracts completed by employers and the lack of regulation by Citizenship and Immigration fail to prevent such violations in contracts. There appears to be no oversight from CIC to ensure that contracts are being upheld and workers are protected. First, CIC merely state that their employment contract should clearly define the terms of their employment. Caregivers who feel as if they are being treated unfairly, are directed to the provincial or territorial labour standards office which directs individuals to filing a claim; however, caregivers are not provided with information on how to deal with instances of unfair treatment. Second, no interviews suggested that there were any consequences to employers who had caregivers work overtime without pay; however, participants did not discuss whether a claim was made to the Ministry of Labour in Ontario to enforce potential consequences. Third, giving employers sole control of the distribution of work hours gives power to the employer. To be eligible for permanent residency, live-in caregivers must demonstrate that they have completed at least 30 hours a week or 24 months of full-time employment. With the power employers have over scheduling hours and duties, live-in caregivers are placed in a position of vulnerability. Live-in caregivers may be vulnerable to having their positions revoked if they do not comply to an employer’s demands of working overtime and performing tasks outside the work contract. Participants caring for elderly employers are in an arguably more vulnerable position in comparison to participants caring for children. In this study, all participants caring for the elderly (n=4) suggested that they were obligated to work for 24 hours without compensation for overtime. As Canada’s aging population grows and the need for live-in care for the elderly increases, this population of caregivers living and working inside the home may continue to be susceptible to vulnerability and exploitation. Furthermore, caregivers caring for relatives may be in a more vulnerable position in contrast to caregivers caring for employers with whom they have no relation. This research demonstrates the complexity of working for family as a caregiver.
Three of the research participants reported working for a family member and two of those participants reported feeling obligated to work overtime hours without pay and perform tasks outside of the stipulated contract while also lacking privacy. While a small sample, it does suggest differences between those caregivers working for family and those who are not. Thus, this represents an important area of future research.

In addition to the breach in contract regarding hours of employment, work duties and a lack of privacy and freedom, the absence of third-party health insurance for caregivers to be provided by the employer poses another violation to work contracts. In this research study, 16 participants reported that they did not receive third-party health insurance from their employers. This represents a clear violation of CIC’s requirement for live-in caregivers to be provided with private health insurance for their first three months living in the province. While this represents a clear violation of CIC and their contracts, caregivers are afraid to report it. Overall, this suggests a lack of regulation on the part of CIC. Changes must be made to ensure that employers are providing third party health insurance. A clear recommendation is that CIC require that employers show proof of third-party health insurance. A failure to comply would result in that employer being suspended from the Caregiver Program until they can demonstrate coverage. Furthermore, 12 participants did not know about the requirement of third-party health insurance. CIC should make it clear to immigrant caregivers that they have the right to third-party health insurance. Upon arrival, CIC should administer a checklist of what foreign caregivers are eligible to have (e.g., third-party health insurance in the first three months). The checklist is to be completed by the caregiver and mailed to Citizenship and Immigration Canada.

This research study also demonstrates how living in the place of employment led participants to work overtime, complete work not indicated in their work contract and a lack of
privacy and freedom. As mentioned in Chapter 1, the new Caregiver Program removed the live-in requirement and is no longer mandatory; however, some employment opportunities may require caregivers to live in their place of employment. The removal of the live-in requirement may lead to a growth of Canadian workers as live-out caregivers; thus, immigrant caregivers may still be required to fulfill the labour shortage of live-in opportunities. Therefore, CIC needs to establish ways of preventing these exploitative work conditions. Policies in the Caregiver Program should include ways of protecting immigrant caregivers. For example, there should be frequent monitoring of contracts between all three parties (e.g., worker, employer and Citizenship and Immigration Canada) as opposed to just observing the initial work contract. Stricter regulations as to who may hire a foreign caregiver should also be implemented. For example, employers who frequently release their workers upon arrival, leaving foreign caregivers without a job immediately after arriving to a new environment, should not be allowed to employ a foreign caregiver.

5.5 Conclusion

As the number of Filipina migrants immigrating to Canada under the Caregiver Program continues to increase and as a result, the number of eligible caregivers becoming a permanent resident in Canada rises, a growing number of immigrant Filipina caregivers are susceptible to experiencing similar issues of declining health and difficulties accessing health care services. Additionally, with a growing population of live-out caregivers, research should investigate the differences of health status and access to health care among live-in and live-out Filipina caregivers. This research provides a vital stepping stone for beginning to understand the complex and important relationship between employment as a live-in and live-out caregiver and health and access to health care services.
References


Asanin Dean, J. and Wilson, K. (20010). “My health has improved because I always have everything I need here…”: A qualitative exploration of health improvement and decline among immigrants. *Social Science and Medicine, 70*, 1219-1228.


Hanley, J., Gravel, S., Lippel, K., Koo, J. Pathways to healthcare for migrant workers: How can health entitlement influence occupational health trajectories? PISTES, 16(2).


Appendix 1: Letter of Information

[University of Toronto Mississauga Logo]

Re: Employment and Health Study

Dear Participant:

This letter is an invitation to ask you to participate in a research project looking at how the Caregiver Program affects the health of immigrant Filipina caregivers. I am interested in your personal employment experiences, your ability to access health services as well as your general health. Overall, I would like to understand how living-in with your employer or not living with your employer influences your health and access to health services.

As a graduate student, this project is part of my Master’s program at the University of Toronto, in the Department of Geography. I will be working under the supervision of Professor Kathi Wilson and Professor Rachel Silvey.

Interviews will take about an hour of your time and participation is completely voluntary. The location of the interview will take place in a private location determined by you and the researcher. You are free to withdraw at any time and you may decline to answer any questions that you choose. Following the interview, if you would like to withdraw the information given during the study, contact me and your information will be removed with no consequence.

If you agree, I would like to make an audio recording of the interview to accurately remember matters discussed. If you wish to not be recorded, notes will be taken if you prefer. If consent for the use of audio recorders is granted, audio recordings and transcriptions of the interview will be used only by the researcher and will be stored in a secure, locked cabinet without your name or any other identifying information. Your information will be kept confidential. In reports or final products, your identity will remain anonymous. Digital recordings will be destroyed once the interview has been transcribed. After five years, all data will be destroyed. The researchers of this study will be the persons to have access to raw data.

While there may be no direct benefit to you from participating in this study, I hope that this research will help improve access to health services by immigrant Filipina caregivers and thus, their health by showing how the Caregiver Program influences such access. Potential risks include the possibility that sensitive or personal matters arise related to employment experiences, access to health services, violation of rights or experiences of vulnerabilities and exploitation. If you feel uncomfortable, you may stop the interview. If you feel that you need to follow up on your interview, please contact myself, a health service provider or someone you feel comfortable
talking to. You may also contact non-governmental organizations supporting Filipina caregivers such as INTERCEDE at (416) 483-4554 or Caregivers’ Action Centre at (647) 782-6633.

As to appreciate your time and assistance with this project, I am pleased to offer $25 in financial compensation as well as reimbursement for any public transportation taken to attend the interview (in the form of bus tickets or tokens).

If you are interested in updates regarding this research project, please provide me with your contact information. At the completion of all interviews for this research project, a summary of the results and initial thoughts involving all participants will be sent. All feedback is welcomed. A copy of the final write-up will be sent and a presentation will take place at [location to be determined].

The results of this research study are intended to be published in academic journals and presented in public presentations.

If you have any questions or concerns about this study or your rights as a participant, you may contact myself at jessica.carlos@mail.utoronto.ca or (647) 968-2377, Professor Kathi Wilson at kathi.wilson@utoronto.ca or (905) 848-3864, or Professor Rachel Silvey at silvey@geog.utoronto.ca or (416) 978-6640. You may also contact the Research Oversight and Compliance Office – Human Research Ethics Program at ethics.review@utoronto.ca or (416) 946-3273.

Sincerely,

Jessica Carlos
Master’s Graduate Student
Department of Geography
University of Toronto Mississauga
Appendix 2: Consent Form

From the Information Letter provided by the researcher, you understand that the purpose of the research study is to understand how the Caregiver Program affects the health of immigrant Filipina caregivers. You acknowledge that the research study outlined in the Information Letter has been explained, that you may ask questions of the researcher at any time during the research process and agree to commence with the interview.

Do you consent to having your one-on-one interview audio-recorded?

___Yes  ___No

I, ___________________________________________ (please print name), acknowledge that the research study has been explained to me, all of my questions have been answered and I agree to take part in a qualitative study examining how the Caregiver Program affects the health of immigrant Filipina caregivers.
Appendix 3: Interview Script

Pre-Migration / Integration

1. Why did you decide to work as a caregiver?
   a. Do you know someone who is a caregiver?
      i. In the Philippines?
      ii. In Canada?
      iii. In other countries?
   b. Did you have any training as a caregiver in the Philippines?

2. Have you worked as a caregiver in other countries?
   a. Where?
   b. How was working as a caregiver in other countries compared to Canada?

3. Have you done any other work besides caregiving in other countries?
   a. Where?
   b. What did you do?

4. How did you hear about the (Live-in) Caregiver Program in Canada?
   a. Why did you choose to come to Canada?
   b. Did you have any expectations about the country? The program? before arriving to Canada under the (Live-in) Caregiver Program? What were they?
      i. Have your expectations been met?

5. How long have you worked as a caregiver in Canada?

6. Do you have any friends or family in Canada?
   a. Did you think it would be important to know people in Canada before you arrived?
   b. How often do you contact family/friends in Canada? How about in the Philippines?
   c. Do you support any family or friends in the Philippines? Probe: remittances

7. Do you have someone you can count on to listen to you when you need to talk? Who?

8. Do you have someone who can give you advice if you are having problems related to life in Canada? Who?

9. Do you have someone who can give you advice if you are having problems related to working as a caregiver in Canada? Who?

**Employment**

10. How many employers have you had while working as a caregiver in Canada?
   a. If one, how long have you worked for that employer?
   b. If multiple, how long have you worked for your employers? Why did you change employers?

11. How did you come into contact with your employer(s)? Agency? Referral?

12. Do you live in the household of your employer or do you live outside the household of your employer?

**Live in**

a. Do you like living with your employer? Why/Why not?
   b. Would you prefer to live-out? Why/Why not?
   c. Do you feel you have enough privacy?
   d. Do you feel you have a space to call your own?
   e. Do you feel you can come and go as you please?
   f. Do you feel obligated to work when you don’t have to?
   g. Does your employer’s house feel like home or a place of employment?
   h. What do you think are some pros and cons of living-in as opposed to living-out as a caregiver? Examples from your experience?
   i. Are there things you would like to do but can’t because you are a live-in caregiver? Probe: Living-in, work hours, location
   j. Do you feel living with your employer (probing with what was stated above) affects your health in a positive or negative way?
   k. Physically? Emotionally? Mentally?
   l. Do you feel being away from your family affects your health? Emotional?
   m. Are you satisfied with your work conditions as a live-in caregiver? Why? Why not?

**Live out**

l. Do you live on your own? With a friend?
   m. Do you like not living with your employer? Why/Why not?
   n. How far away do you live from your employer? How do you get to your employer’s house?
   o. Would you rather live-in? Why/Why not?
   p. Does your employer’s house feel like home or a place of employment?
   q. What do you think are some of the pros and cons of living-out as opposed to living-in as a caregiver? Examples from your experience?
   i. Are there things you would like to do but can’t because you are a live-out caregiver? Probe: living-out (costs associated), work hours, location
r. Do you feel not living with your employer affects your health in a positive or negative way? Why?
  
i. Physically? Emotionally? Mentally?
  
s. Do you feel being away from your family affects your health? Emotional?
  
t. Are you satisfied with your work conditions as a live-out caregiver? Why? Why not?

13. Can you describe what a typical work day looks like?
   a. Probe: How many hours?
   b. Were all your tasks outlined in your work contract? Do you ever work more? Is it paid for?

14. What do you do on your free time/days off?
   a. Is it a time to relax?
   b. Who do you spend time with on your days off?
      i. Do they enjoy similar social activities? (e.g., church)
   c. Do you contact your family/friends back in the Philippines on your days off?

Health

15. How would you describe your overall health?
   a. Why do you say that?
   b. Physical health?
   c. Emotional and mental health?

16. How has your health been since moving to Canada? (stable, improved, declined)
   a. What do you think caused this change/stability?
   b. Has it been easy to maintain being healthy in Canada? Why/Why not?

17. If you, or other caregivers, needed information about Canadian health care coverage, where would you look? Online? Other Caregivers? Resources from agencies?

18. Did you apply for OHIP when you first arrived to Canada?

19. During the 3 month wait period to receive OHIP coverage, did your employer provide third party health insurance?
   a. What did your third party health insurance cover?
   b. Is there anything you needed that was not covered by this insurance (Dental? Prescription Drugs?)?
   c. Did you require any health services during the 3 month wait period? Type? What did you do?
   d. If not: Are you aware of the third party health insurance to be provided by employers during the three month wait period?
      i. Has anyone checked to see if employers provide third-party health insurance?
         i. Agency: to follow up with you about health care coverage?
            Government agency?
ii. If you needed health services/prescriptions, etc., were you able to afford it? Pay out of pocket?

20. Do you currently have extended health benefits?
   a. Who covers those benefits? Yourself? Employer?
   b. Required? Not covered? Probe: What is covered?

21. Do you have a regular health care provider?
   a. Who (family doctors/walk-in clinic)?
   b. How did you find this health care provider?
   c. Was it easy/difficult to find this provider (identify if they say doctor etc)?
   d. If no doctor: Any reason why you don’t have a family doctor?

22. In the past 12 months, how often did you see this provider?
   a. Do you think being a (live-in) caregiver make it easy/difficult to see a doctor when you need it
      i. What aspects of your job make it easy/difficulty? (Days of work? Hours? Location: Travel time?)
   b. How do you get to the doctor? Is there someone who can take you to the doctor if you need it?
   c. Thinking about your last visit to the doctor, were you satisfied with the care you received? Why?

23. In the past 12 months, did you need health care but didn’t receive it? If so, why (probes: hours of operation, location, cost, working conditions)? Do you think this affected your health?

24. Are you able to discuss difficulties in accessing health services with your employer? Are they able to help you/Have they been able to help you?

Additional

25. What are your thoughts on the changes to the Caregiver Program? Probe: specifics Suggestions for improvements?

26. Is there anything else you would like to add?
Appendix 4: Demographic Survey

Survey

Were you born in the Philippines? (circle)
Yes  No

Year of birth: ______________

What did you study in the Philippines? ____________________________

What is your highest level of education? ____________________________

What type of work did you do in the Philippines? ____________________________

When did you arrive to Canada? ____________________________

Which program are you enrolled in? (circle)
  i. Caregiver Program
  ii. Live-in Caregiver Program

Which pathway are you enrolled in? (circle)
  i. Caring for Children Pathway
  ii. Caring for People with High Medical Needs
  iii. Live-In Caregiver Program
Appendix 5: Recruitment Poster

Are you currently working or have previously worked as a caregiver under the (Live-in) Caregiver Program?

Researchers from the University of Toronto are looking for participants to talk about:
- Your experiences settling in Canada
- Your work experiences as a caregiver under the Caregiver Program
- Your accessibility to health care

Participants will be compensated for their time.

Participants must be:
- from the Philippines
- have a minimum of 6 (six) months work experience as a caregiver under the (Live-in) Caregiver Program

To learn more about this study please contact: jessica.carlos@mail.utoronto.ca

(647) 243-7633
jessica.carlos@mail.utoronto.ca

(647) 243-7633
jessica.carlos@mail.utoronto.ca

(647) 243-7633
jessica.carlos@mail.utoronto.ca

(647) 243-7633
jessica.carlos@mail.utoronto.ca

(647) 243-7633
jessica.carlos@mail.utoronto.ca

(647) 243-7633
jessica.carlos@mail.utoronto.ca

(647) 243-7633
jessica.carlos@mail.utoronto.ca

(647) 243-7633
jessica.carlos@mail.utoronto.ca