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Working Multiple Shifts: Intersecting Dynamics of Gender, Employment Status, and Immigrant status in the Experiences of Immigrant Caregiver-Employees in Urban--Rural Canada

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Abstract

Globalization has fuelled the migration of skilled and unskilled immigrant workers to Canada. Very little is known about immigrant Caregiver-Employees (CE's) working in the health sector, especially outside of Canada's large metropolitan centres. The purpose of this case study was to understand the experiences of 13 female immigrant CE's employed in the health sector in Grand Erie, a medium-sized region made up of urban and rural communities, in Ontario. Intersectionality and constructivist grounded theory guided the theoretical and analytical processes, respectively. Study findings reveal that multifaceted intersections of: gender, employment status, and immigrant status shape immigrant CE's formal and informal caregiving roles, as well as their health. Forced into precarious employment, participants found it increasingly difficult to balance paid and unpaid caregiving duties. They remained silent about their deteriorating health for fear of losing their job(s). As the demand for both formal and informal caregivers continue to rise due to an aging population, it is critical that government and employers take an active role in supporting the economic, social, and health integration of immigrant CEs.

Introduction and literature review

Caregiver-Employees (CEs) are defined as family members and other significant people who provide care and assistance to individuals living with debilitating physical, mental and/or cognitive conditions, while also working in paid employment. CEs can be caring for a parent, parent-in-law, spouse, life partner, adult child, or friend. CEs are a new category of worker, created as a result of numerous demographic changes, such as: smaller family size and more women in the work force; community health care provision realties of the 21st century, such as early hospital discharge and global capitalism, and; increasing employee mobility. Evidence suggests that family caregivers play an increasingly important role in maintaining the well-being of family, friends and/or relatives with age-related needs and/or physical, cognitive, or mental health conditions [1-5]. It is estimated that the economic contribution that caregivers provide, in the form of unpaid labour in Canada, approximates 24 billion dollars [6]. While the caregiver's contribution to the economy is impressive, the findings related to their health reflects a disturbing picture. Past studies have shown that informal or familial caregiving can negatively impact the physical and psychological well-being of caregivers [7,8]. The limited literature on CEs reveals that workplace overload can lead to spill-over effects at home, and home stress due to caregiving can lead to negative effects at work, particularly for women who do not disengage as much after work as compared to men [9]. More female than male caregivers are "sandwiched" between raising children and caring for their parents or parents-in-law [10].

Recognizing a different country context, Chou *et al.*'s Tawaiinese study [11] found that individuals who work "simultaneously as paid formal caregivers and unpaid informal carers" have a lower quality of life than those who do not function as dual workers [11]. Interestingly, in Chou *et al.*'s study [11], the home care workers in Taiwan were employed in a workplace characterized by: low salary; lack of training; lack of promotion; high risk; high stress; irregular working hours; geographical isolation; uncertain career development, and; high turnover. It is noteworthy, that the majority of home care workers in Chou *et al.*'s study [11] were women (92.6 %). Zeytinoglu*et al.*'s [5] research on homecare workers in Ontario recognized similar working conditions, and found that those employed casually were intending to leave their workplace. Similar to Chou *et al.*'s [11] study, the majority of participants in Zeytinoglu*et al.*'s [5] research was female (94%).

Much of the research on CEs, however, fails to collect data on immigrant CE's. This is true in Canada as well, despite the fact that immigrants represent 20.6% of the total Canadian population, the highest proportion among the G8 countries [12]. Further, one in every five people in Canada is a visible minority (19.1% of the total Canadian population). Of these visible minorities, 65.1% were born outside of the country, and 30.9 % were born in Canada [12]. Many of these immigrants are now providing caregiving to a family member, friend,

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and/or relative. Further, some of this care is transnational due to an increase in global mobility and the aging of the population worldwide [13,14]. Transnational care refers to providing moral, emotional, and/or financial support to an adult family member, relative, and/or friend across international borders. Considering the recent changes to immigration policy in Canada, the demand for transnational caregiving is expected to rise. Unlike previous decades, when family reunification was a corner stone of Canadian immigration, current skill-based immigration policies favour young educated immigrants who have the ability to drive Canada's economic growth [15]. The new sponsorship laws have made it difficult for immigrants to sponsor their elderly parents/grandparents, as these individuals are considered a burden on the Canadian health care system [16].

Most studies on immigrant CE's are focused on live-in-caregivers who are hired by private individuals to take care of children, the elderly, or persons with disabilities without supervision [17,18]. While these studies are important, it is essential to recognize that for many immigrant CE's coming from collectivist-patriarchal societies, it is women who are expected to sacrifice their own needs for the needs of their husband, children, elderly parents, and in-laws. CEs are faced with managing simultaneous paid work and unpaid caregiving responsibilities, often encountering role strain (having to balance multiple work-family roles and responsibilities). Role strain may force them to sacrifice one of their two or more roles, and/or face negative health outcomes. In addition, as Canada continues to rely upon immigrants to fulfill labour market shortages created by retirements [19], it can be expected that the flow of skilled and unskilled workers to Canada will continue to rise in the coming years. Some of these labour market shortages are expected to be in the health care sector, and with the health care sector expected to be the fastest growing industry in Canada, there will be a growing demand for health care workers [20,21]. The government is, in part, relying upon immigrants to meet the growing demands for health care workers, evident in the initiative, *Skills Connect for Immigrants program* (*http://www.skillsconnect.ca/)*, specifically created to attract immigrants to the health care sector, among others. Thus, it can be expected that immigrant CE's will occupy many health care positions.

In light of a growing immigrant population and their expected contribution to the health care work force, studies are needed to examine immigrant CE's employment and informal care experiences. The current study contributes to better understanding immigrant CEs experiences by simultaneously exploring their: 1) unpaid, informal caregiving experiences, often informed by cultural and familial obligations, and; 2) paid employee experiences in the health care field. The context for this research includes the rural-urban region, as we know little about the immigrant experience outside of a large urban centre, particularly given the transnational context.

The study

The primary purpose of this study was to explore the lived experiences of immigrant CEs living and working in Grand Erie, Ontario, with respect to their simultaneous involvement in paid health care work and unpaid caregiving work in Canada and/or transnationally. Grand Erie is a middle-sized urban-rural region in Southern Ontario, Canada with an estimated population of 237,339 [22]. Our goal was to understand the economic, health and social consequences of doing paid and unpaid caregiving *simultaneously*. The research question guiding this study was: How do immigrant CEs' informal caregiving and paid work impact their economic, health, and social outcomes? As reported elsewhere, we also interviewed 20 employer and/or managers working in the health care sector [23]. The health sector was defined broadly to include those working in the following health care settings: nursing homes, hospitals, palliative care facilities, and long-term care facilities. In this paper, we report selected findings from the interviews with immigrant CE's.

Conceptual framework

Intersectionality theory provided the conceptual framework for this study. This theoretical framework is rooted in social justice epistemology and concerned with the lived experiences of marginalized populations. Unlike traditional research that focuses on single dimensions of identity (such as race, class or gender) when examining oppression, intersectionality theorists recognize that "individuals' economic, political, cultural, subjective, and experiential lives intersect to create a whole that is more than the sum of its parts" [24].

Methodology

Participant Recruitment

Following research ethics approval from the McMaster Research Ethics Board (Project No.2014 120), this study employed maximum variation purposive sampling to recruit female participants (n=13) characterized as immigrant CEs from diverse backgrounds (immigrant group, educational, socio-economic, religious, etc.) and from various health sectors across Grand Erie. The criteria for participant selection was as follows: immigrants engaged in paid health care work and an unpaid caregiving role within the region of Grand Erie; spoke English, Hindi, or Punjabi (the first researcher has knowledge of these languages), and; were voluntarily willing to participate in the study. To ensure fair and equitable selection of participants, a queuing (first come, first served) method was used to select subjects.

In order to enhance the diversity of the CE sample with regards to race, gender, age, educational and professional background, ability, sexual orientation, and occupation, a number of strategies were used to recruit research participants. This included distributing recruitment fliers at community events; sharing fliers with key-informants from diverse ethno-cultural groups, such as religious leaders; posting recruitment fliers in laundromats, ethnic stores, grocery stores, and other such places frequented by immigrant CE's, and; mailing research information to local community agencies, hospitals, and nursing homes in Grand Erie.

Data collection and analysis

A qualitative approach was used to gather data and access participant'smultiplerealities, and capture the deeper meaning of their lives [25-27]. Demographic data was collected through a brief questionnaire (i.e. age, income, education, number of years of caregiving), which accompanied an open-ended, face-to-face, semi-structured interview. These interviews were conducted at the participant's choice of location in order to help them feel safe and comfortable (i.e. home, library, coffee shop, etc.). An intensive style interview technique compatible with qualitative research was used to gather an in-depth understanding of the participants paid and unpaid caregiving roles, while accessing the hidden nuances of their post-migratory lives [28]. In keeping with the tenets of intensive interviewing, each participant about their paid work and unpaid caregiving roles, listening with sensitivity while the participant did most of the talking [28]. Broad, open-ended questions were utilized; however, there was no fixed sequence in which the questions were asked. The purpose of the interview was to allow participants to speak

freely about their resettlement experiences, beliefs and/or motivations. Questions were intentionally asked in a manner that captured the dynamic intersectionality's of participants' social location (such as race, gender, class, immigrant status, etc.) given the interface of paid and unpaid work [29] For example, participants were asked, "How is your familial caregiving role impacted as a Black immigrant woman?" Each participant received a $25 honorarium for participating in the study. The audio-taped interview lasted between 45-60 minutes. Once the interviews were transcribed verbatim, the qualitative data was analysed using Charmaz's grounded theory [28]. and intersectionality theoretical framework [24]. To maintain the authenticity of the participant quotes we have not corrected grammatical errors.

Findings

Participant profile

Although we tried hard to recruit male CEs, we were only successful with female CEs. The thirteen participants were all female, identified themselves as the primary caregiver, and were unpaid caregivers. They were all caring for an adult family member, friend and/or neighbour suffering with various health conditions. Two CEs cared for adult family members with more than three health conditions. Participants provided unpaid care for various amounts of time each week. Only two participants had some help to take care of the family member/friend. Participants' ages ranged from 35 to 64. Most were Canadian citizens (n=10). One participant lived in Canada for less than five years, 5 were residing in Canada between 10-15 years, and the remaining seven had been living in Canada for over 15 years. Most participants (n=8) were married. Eight women were residing in the same home as the care recipient. Participants worked in a variety of health care settings. Only one was self-employed. The remaining 12 had full-time and/or part time paid work outside of the home. Ten participants reported their household income between Canadian $30,000 and $59,999 and the household income of one family surpassed $70,000. Two participants declined to provide income information. Income adequacy was reported between very well to totally inadequate (n=1) and completely adequate (n=2). Table 1 provides a detailed description

Table 1. Description of caregiver characteristics (n=13).

Characteristics	Number = n
Age	
35-44	4
45-54	6
55-64	3
Ethnicity	
Black/African	4[1]
Asian	3
Caucasian (white)	3
Mixed ethnic origin	2
Jamaican	1
Immigration Status	
Canadian Citizen	10
Landed Immigrant or Permanent Citizen	2
Work Visa	1
Number of years living in Canada	
Less than 5 years	1
10-15 years	5
More than 15 years	7
Country of Birth	
Africa	3
Serbia	1
Portugal	2
India	1
Philippines	1
Singapore	1
Jamaica	1
England	1
Yugoslavia	1
Puerto Rico	1
Level of Education	
Registered apprenticeship or trade certificate	5
College, GCEP, or non-university diploma/certificate	5
University degree-Bachelors	1
University degree-Masters	2
Lives with the care recipient	
Yes	8
No	5
Number of dependents[1]	
One	2
Two	4
Three	2
Four	1
Five or more	2
Zero	2
Sector of work	
Home Care (including PSWs)	4
Aesthetics	1
Social Services	3
Nursing	1
Public Health	1
Pharmacy	2
Human Resources in Health Sector	1
Location of Occupation	
City of Brantford	10
Haldimand County	1
Brant County	2
Years in Employment	
Less than 5 years	5
5 to 10 years	5
10-15 years	1
More than 15 years	2
Employment Status	
Full-time	5
Part-time	2
Contract	3
More than one job	2
Self-Employed	1
Relationship to care recipient	
Spouse	4
Parent	3
Son/daughter	4
Friend	1
Aunt	1
Time in caregiving role	
Less than 1 year	1
1 to 5 years	3
5 to 10 years	5
10 to 15 years	1
Greater than 15 years	3
Number of hours spent providing care, per week	
< 5 hours	2
5-10 hours	3
10-15 hours	1
15-20 hours	2

20-25 hours	5
Help with caregiving	
Yes	10
No	3
Currently practicing religion	
Yes	11
No	2
Income	
$30,000 - $39,000	6
$50,000 - $59,000	4
$70,000 or more	1
Prefer not to answer	2
Finances meet needs	
Very well	1
Adequately	2
With some difficulty	7
Not very well	1
Totally inadequately	2
Marital Status	
Married	8
Divorced or separated	5

[1]Any member of the family that they were financially responsible for (i.e. children and/or parents).

of the demographics of the 13 participants.

Four themes emerged from participant's narratives; these included: 1. Immigrants meaning of caregiving, 2. Intersecting realities in managing multiple shifts, 3. Deskilling and racism, and Resilience and coping.Participants chose their pseudo names for the study.

Immigrants meaning of caregiving

For most of the participants, taking care of an ill and/or aging family member was a personal responsibility and an obligation. In her quote, Ena, a Registered Practitioner Nurse (RPN) reflects this sentiment on family responsibility: "In my own experience, caregiving is part of our...what is it? Family ties? It is a responsibility. It is a family tradition that is done for a long time." The intersections of culture and gender were evident in most women's narratives. As female immigrants from patriarchal cultures, they were primarily responsible for domestic chores and caregiving. "Yes! I am from Zimbabwe. In our culture, mostly women provide care if someone is sick. We are the ones who are responsible to provide care" (Tonderai). Dealer, also from Zimbabwe, agrees with Tonderai: "I remember when my father was...Before he died, my mother is the one who used to do the care every time, and my other aunt was also helping my mom. My uncles, they were very rarely there. They only come and talk with him. But I saw it is women who provide care." Both, Tonderai and Dealer were working as personal support workers (PSWs). PSWs (also referred to as "homecare worker, home support worker, ancillary worker, social and health care assistant, homecare assistant or aide, and home health aide") are "unregulated workers and do not have a body that oversees their ongoing professional development as a requirement for the continuation of their certification like regulated health care workers such as nurses and therapists" [30, p.180].Further, they are also often employed casually or part-time, so have limited benefits. The European participants agreed with the visible minority women that, in their culture, caregiving was largely a woman's role. Mary, working as a contract worker in social services, notes:

My niece's father is a financial provider. He works, he brings home his money; he contributes to the family financially. In terms of physical help with her, or even emotional support to his wife, because she is the one providing care to my niece, uh that essentially it was not existent. So, he never lifted a finger to help with my niece, never.Bibi, a pharmacist and a European immigrant, has a similar perspective to Mary: "He (brother) would bring her (mother) to the doctor. But, he cannot give her help with her bath."

Sam worked as a social worker, and negotiated two cultural boundaries - eastern and western. She also managed gendered expectations of her East Indian heritage with her Western upbringing and lesbian identity. Her long and powerful quote implicates several intersectionalities of ethnicity, gender, sex, and age:

So, in terms of the cultural piece - it's a moving target sometimes. It means that culturally, I am aware of shifting, conflicting feelings about who am I as a caregiver and as a mother in this young man's life. Uh, so that is culturally. In terms of gender, as a woman and as a woman whose background is East-Indian, I feel the tug and pull of what that looks like from my heritage. Uh, I am living in a Western culture and as a lesbian it also means that my ability at 48 to be an individual adult woman that shares parenting and has a young man as a son, means that the shift in that needs to be me pulling back more. His father needs to take more of a step, a role into that caregiving role and role modeling and providing my son with more opportunities to negotiate this world more on his own.

The study results also reveal that since all the participants inhabited collectivist society's pre-migration, their meaning of caregiving as a personal responsibility and obligation extended beyond family to include neighbours. Ena states: "Even if it's a neighbour and they can't help themselves, then you assist them the best way you can. Other people will come and help, if they're your neighbours or if they're your family." Sophie, a PSW, adds: "When I have a neighbour who is in need or a family member who needs care, to us it is not like caregiving it is part of daily living. It is part of your chores." When Sophie's neighbour in Canada needed caregiving, she volunteered to help but initially met with some resistance: "She, (my neighbour) is Canadian and first of all when I offered to help she didn't take me as somebody who was 'intellectual'. She just thought, 'Oh! What can she know? How can she provide care?" Until she saw me doing the care, that's when she built the trust. Further probing as to why her neighbour would not consider her 'intellectual' elicited the following response: "I don't know. I didn't really…she withdraws first [Laughing] She didn't really…. Perhaps because I am an immigrant or my colour…" Over time Sophie and her neighbour bonded and, at the time of the interview, she continued to be her primary caregiver while working two paid part-time caregiving jobs.

Intersecting realities in managing multiple shifts

Similar to Sophie, all other study participants were also engaged in multiple shifts, meaning they were: 1) providing unpaid care (sometimes to more than one person; 2) were taking care of children/spouse/in-law/sibling that were not ill, and; 3) had one or more paid jobs in the health sector. Krishna, working in front line social services, eloquently articulates the above stated concept of 'multiple shifts' that women from patriarchal cultures are expected to do:The hard days are when I have to do few massages in one day because I get so tired
and then when I come home I have to take care of my husband, father-in-law and my kids. I have to do all that stuff all over again. In my culture, I am expected to do that because I am a woman.

Along with Sophie, five other participants had two paid jobs as

health care providers, while also working as unpaid caregivers to an adult family, friend, and/or neighbour. For some of the participants (n=5) unpaid care took the form of transnational caregiving.Tonderai, a primary caregiver to her daughter who lives in the United States, had one full-time and one part-time job as a PSW. She estimated that she worked approximately 100 hours per week in paid employment and had no help with unpaid care. Similarly, Dealer provides transnational care to her mother. She has one full-time and one part-time job. Her narrative illuminates her experience with multiple shifts:

I work night shift-from 11 to 7, I'll be at work. When I come home in the morning, I get children ready for school. Then I'll get, like 4 hours during the day to sleep. Then when my children come, I have to help the little one with homework. If I finish, then I have to go again and sleep for another 2 hours. Then I have to go to work again...You are always at work. Working, working, working…while engaging in caregiving duties simultaneously.It is noteworthy that only two participants indicated that they had some minimal help with unpaid caregiving duties. Sam, who relies on contract work to meet her financial needs, provides her reasons for soliciting some paid help: "Yeah, it is a full-time caregiving job. And sometimes it means that I've needed to resource out and pay for it or have other people do professional's work with my son in ways that I don't have the emotional capacity to do with him…" As a result of working multiple shifts, participants had no time for self-care or leisure. As Carmen, a health care Human Resource specialist, pointed out:Everything was scheduled to the minute. So much, so that if I want to pick up prescriptions for my mother, uhm.... I get some delivered but sometimes you have to go to the pharmacy and talk to the pharmacist. I'd be in a panic. Well, what if I see someone I know and then want to stop and talk. I just don't have time for that and the same thing racing around getting the groceries. Everything's timed …." Within the larger theme of managing multiple shifts, three sub-themes emerged to explain the participants' intersecting health, economic, and familial realities as a result of managing paid and unpaid care concurrently: A) caregiving and health; B) caregiving and career, and; C) caregiving and family relationships. Below, these sub-themes are briefly explained.

A) Caregiving and health

Consequent to working multiple shifts, participants were chronically sleep deprived and tired: "Okay. My health, I can say it has deteriorated, because if you are not getting enough sleep, you always get headaches, and your heart always pumps so fast. So, those are some of the health issues which I'm starting to have, because I'm not getting enough sleep" (Dealer). Other narratives suggest that integrating paid and unpaid care impacted women's physical health. "Sometimes I think I continue like this, I am going to be the one land on wheel chair....my age and physical demand of work.... it's too much but I cannot leave my job(s)" (Tonderai). Susan's quote provides evidence of emotional entrapment, "Emotionally, you just feel like you are trapped." (Laughing). Gardiner, a public health specialist and a busy mother of two daughters, worked full-time and provided care to her husband after his heart attack. She gasped:Well, caregiving impacted my health because I wasn't taking care of myself. I wasn't even considering how much exercise I was getting. I used to walk. I wasn't taking care of what I was eating. I probably drank more wine than I should have...So I gained weight. And it's taken a long time to even think about myself again. I haven't done anything that is just for me like exercise and things like that...Yeah! Caregiving definitely had an impact on my physical health.

B) Caregiving and career

Along with their physical and/or mental health, most participants (n=11) agreed that caregiving disrupted their career goals; that is, they had no time to think about their career or had to put it on hold. Mary, for instance, had a desire to continue with her education. However, she had to put that on hold, as evident in her long and potent quote:Yeah, yeah, I don't even know that I.... I have put everything on hold. I haven't even cleaned my house in five weeks [Laughing]…I haven't even had my dog at home in five weeks. So, my career goals at this point in time: I want to honestly hold on to the employment I have - and I do say "hold on" very carefully. Uh, I live and work contract to contract, and I uh, at this point in time I did want to resume my education because there is something I.... I want to... I have something I wanted to finish. I don't know that I even want to finish it any more, my view of the world has changed so much. I sort of live moment to moment, day to day.

The issue of contract and part-time work, as evident in Mary's quote was particularly prevalent in women who worked as PSW's. As Sophie states: I haven't had an opportunity to get full-time work. They will post …. but because of seniority and stuff like that and the other problem is because you are part-time here, you are not guaranteed so many hours so you end up juggling between two jobs just to make ends meet. So, when you juggle between two jobs your seniority is not as good as one who is working all the hours on one job. So, when a job is posted you kind of not qualify to get into full-time because you are always somewhere here, two hours here, two hours there. That is why it is kind of very difficult to get into a full-time job.Similar to Mary, Dealer - who provides transnational care to her mom and works as a PSW in one full-time and one part-time job, put her nursing career on hold even though she was admitted to the nursing program. She summarizes: I wanted to go ahead with the nursing program, but now, because of my mom getting sick and everything is too.... Like, I have too much on my plate, I can't balance it, and it's kind of like stressed out. I finished my prerequisites for my nursing, but to go into the nursing, I'm just afraid that if I start, then that means I'm not going to take care of my mom. That's my fear.

C) Caregiving and family relationships

It seems that in taking care and sacrificing their careers, participants realized that based on limited time between paid and unpaid caregiving, often they were unable to devote attention to other family members who were not the care recipients. Krishna was so busy providing care to her husband and father-in-law while working full time that she was unable to attend her son's rugby tournaments. Tearfully she explains: "…like my oldest plays rugby and many times he would ask me if I am going to his game and I would say, 'No! I have to look after dad,' this and that…so he stopped asking and he would not ask me again..." In the past year she has made a genuine effort to reconnect with her son: "We sit and talk and he still has that in his heart and the other day he said, 'But you did not come for any of my games' and I start to cry and I said that I did not go to the games not because I did not want to but because I had to look after dad…and cook and do all the work. And he said, 'No, no. I understand.'" Tonderai was unable to financially support her nephew's education in Africa due to spending a large portion of her paycheque in supporting her daughter's rent and meals in the United States: "I have delayed paying my nephew's school fees. He said, 'Aunty I need the money for the university.' I know that I have to send money. It really affected me because I am paying for my daughter."

For Iza, a pharmaceutical assistant occupied in part-time work, the

burden of multiple shifts impacted her relationship with her husband, the care recipient. Lowering her eyes, she whispers: "It (working and caregiving) is keeping us far from each other. No more intimacy…It is hard, yeah…We argue most of the time. Yeah. Fight. And sometimes it is not good for our daughter. I don't like to argue in front of our daughter but sometimes it happens". On the subject of intimacy, Gardiner shyly provides another perspective on intimacy: "Well in terms of our marital relationship…the intimacy went. Well, it was done for quite a while. He was in no physical condition. Like the desire or physical ability was not there for a number of months. It was probably the first half of the year. And the funny thing is that the first question my husband asked the doctor after waking up from the operation was, 'When can I have sex with my wife?'" (starts to laugh). While Mary experienced similar challenges as other participants, she found that caregiving helped her reconnect with her relatives. For Mary, it is culturally expected that family or close friends take care of loved ones; it is not an outsider's role to do so. She accepted help from any family member that was available, including her elderly aunt whom she hadn't seen for several years. She heaves a huge sigh as she states:When my sister became incapacitated immediately, we didn't have anyone. So it's my aunt that is 75 years old, and my best friend, who has a heart condition, and she is 54 and the reason she is not working is because she has a heart condition. So, we are calling upon, and we are accepting help from who is offering it, in whatever way that would help us, you know, and not make their lives a struggle as well. Yeah.

All the participants were in agreement that caregiving would have been much easier in their country of origin, as they would have a lot of social support from family and friends in providing care. However, in Canada they had weak social capital. Further, the findings also suggest that none of the women had heard about Caregiver Friendly Workplace Policies (CFWP's). These are "deliberate organizational changes – in policies, practices, or the target culture – to reduce work-family conflict and/or support employees' lives outside of work" [31]. Some participants (n=7) were not even aware that they could receive homecare services. Regardless, as Carmen's quote suggests, women were willing to pay the cost of caregiving and fulfill their familial obligations: "When I'm really tired, I find I don't speak well, I don't think well. Even routine tasks, I don't do as well and that bothers me a lot but, it's the price that I decided. I am willing to pay to give my mother what she needs. She cannot go to long-term care because she needs one-on-one care."

Deskilling and Racism

When asked why they had chosen a particular profession, ten participants stated that they had no choice. These women were either university educated and/or working in professional jobs pre-migration and came to Canada with hope for a better life. However, post migration, the education and skills obtained in their home country was not recognized. They were deskilled and working in jobs that did not require university education. Ena's nursing degree was not recognized in Canada. Tired of working as a PSW, Ena obtained her nursing degree in Canada while working full-time and provided unpaid care to her mother. Another PSW, Tonderai, was an executive assistant in Zimbabwe. When she migrated, she could only secure jobs such as catching chickens. She moved to Brantford from a larger city, as there was demand for PSW's. This transition from a secretary to a PSW was difficult:Oh, my God! That was so hard. There, as a secretary I work from 8 a.m. to 4 p.m. I take minutes, make appointments… On Fridays, I work from 8 a.m. to 3p.m. and then go to get my hair done. Because back home I always volunteer to help people but it's not work. Here I have to work, to take care of people for money. Oh! It was so hard…

Iza, a chemical engineer from the Philippines worked as an office cleaner before she obtained her pharmacy assistant diploma in Canada. Likewise, for Janavi, getting her Human Resources (HR) certification in Canada while working full time and providing care to her mother transnationally was a very long and tedious process. In Singapore, Janavi had a thriving career as an HR executive. However, post migration she had to redo the entire certification process. Even then, she cannot find a job in her field. With a tone mixed with frustration, anger, and pain she states: I now have my human resources certification in Canada. I have my immigration certification in Canada. I have got my human resources licence in Canada. I have had this for the past eight years. I have not been able to get an HR job in Brantford. I have not been able to get an HR job in any of the close cities nearby. When probed further about why she does not relocate to a larger city, where perhaps her HR certificate may be recognized, she explains that she is stuck in this vicious circle where she cannot take time off to travel to another city in search of a more suitable job for fear of losing her current job and she needs the finances to provide transnational care.

Other participants' narratives illuminated another aspect of geographical location (living in large urban centres or small towns and rural regions). Participants expressed experiences of racism (mainly women working in home care jobs). They believed that it may be because "Brantford is more white" (Susan), compared to larger urban centres, and most of the clients in homecare in this city are white. As Dealer notes:Yeah, the clients which I take care of, they are all white. Some of them, I believe, they didn't used to have to see people -the black people -taking care of them. So, sometimes it's kind of a surprise to them, especially with my homecare job.

Janavi shares her opinion on geography and racism: "Greater Toronto Area has a more diverse environment. The employers there are more diverse. It doesn't mean that biases do not exist there. But here, it's at a mind-blowing level. It's at an unacceptable level." Janavi described racism as "not a pleasant experience" For Dealer, the experience of racism was "hard." Tonderai expressed that she "felt like nothing" whenever she encountered racist behaviour. We have written on participants' experiences of racism and microaggression elsewhere [32].

Resilience and Coping

All of the women's narratives reflected incredible resilience in integrating work and care. Despite their physical and mental hardships in managing multiple shifts and/or experiences of racism, women were grateful for their life in Canada. Mary notes: I think we have much to be grateful for. We have very much to be grateful for. Uh, and one of the things we have to be grateful for is that, as much as you do get some pretty rotten people working in a screwed up system, you also have some really good people working in a screwed up system. So, we've had really good care.

Most participants practiced their faith (n=10) as a way of coping with their hardships. One participant who did not practice her faith did believe in some form of higher power and another who did not regularly pray did partake in religious functions of which she was a member. For Iza, her church family was a particularly important source of comfort post-migration, as she did not have extended family in Canada. She relied on faith to keep her spirit healthy: "Oh, for me, faith is everything. If I don't go to church on Sunday, I have a hard week because I know I have to have one day for God to keep

my spirit life healthy. And if my spirit is not healthy then everything else will fall..." Women who provided transnational care prayed with their loved ones across space and time. Working multiple shifts, time was a source of privilege. When they did find time, women socialized with friends around home cooked meals. The traditional dishes had great significance culturally; they did not just signify 'food' but rather represented a cultural thread that bonded them to their home country. Dealer describes one of the ways she copes and unwinds:Sometimes, like, when we have time with my friends, some of the people who come from my country, we plan to do the small party. Then we do potlucks and we try tocook our meals like back home, and then we put together and we eat and we dance. That's when we have that time when we have fun. We try to do that."

Discussion

The gendered nature of caregiving has received extensive research attention. While the current study findings added to the important conversations on gender and caregiving, they uniquely illuminate the impact of ethnicity, geography, sexual orientation, and immigrant status, and the intersections of these with gender to influence CE's economic, social, and health outcomes in Canada. Similar to other studies [33-35], this study confirmed that immigrant CE's experience the unforeseen decrease in their socio-economic status as their human and social capital was not recognized in Canada. They were deskilled, which refers to immigrants working in jobs that do not commensurate with and are lower than their skill level, work experience, and/or educational level. As noted in the findings, Iza was a chemical engineer from the Philippines who worked as an office cleaner before she obtained her pharmacy assistant diploma in Canada. Janavi, an HR specialist from Singapore continues to struggle with finding employment in her field equal to what she had back at home. Research indicates that ethnicity matters in immigrants' experiences of deskilling and/or economic integration. For example, visible minority immigrants are much more likely to have lower employment earnings than Canadian-born workers [33]. Man's [34] work on Chinese immigrant women demonstrates that deskilling of immigrant women in Canada "is complicated by the contradictory processes of globalization and economic restructuring, with its polarizing effects along axis of gender, race, ethnicity, class, and citizenship".

The down grading of immigrants' socio-economic status forces them into in non-regular and insecure employment [34,35], such as with those working in the homecare sector. Ena, for example, a visible minority immigrant, worked as a homecare worker for several years before she was able to obtain her nursing degree in Canada. Some of these homecare workers (n =3) were working two jobs, often on limited contracts, yet their income was not sufficient to meet their financial obligations. Only one participant in the study sample of 13 indicated that her income was sufficient to meet her financial obligations. Economic globalization and neo-liberal policies that favor privatization of health care, reduced government spending, and empower employers over employees have been primarily responsible for the increase in precarious employment in Canada [34]. Since the health care restructuring of the 1990's in Canada, the health sector home care industry is increasingly employing workers under precarious employment contracts [5,36]. Currently, between "25 to 30 per cent of all jobs in Canada share one or more characteristics of precarious work" [37], characterized by employment insecurity, low levels of pay, part-time or contract work, low work autonomy, working on call, casual employment, involuntary hours, etc.) [37,5]. Additionally, "women, recent immigrants, racialized persons, visible ethnic communities, aboriginal workers, LGBT persons, youth, persons with disabilities, and persons with uncertain legal status" are more likely to be affected by precarious work" [37]. Research suggests that time is a risk factor for caregiver role strain, particularly for women [38].

More work is needed to better understand and examine CE's health as a result of doing multiple shifts. It is noteworthy that the theme 'multiple shifts', as presented in the current study, is similar to the well-known second shift concept coined by Arlie Hochschild [39], in that immigrant women were not only active in the paid labourforce, but also working at home. Although the participants in this study were also participating in a second shift, it was unique in that they were performing similar kinds of caring work in both the paid and unpaid health care sector, and that some of the participants (n=5) were doing a third shift (taking care of people transnationally and/or working a second job, also in the health industry). Women's narratives in our study demonstrate that lack of time for leisure or self-care created physical and/or mental health challenges. Furthermore, as women from collectivist- patriarchal societies, participants were expected (that is, they did not have a choice) to fulfill the challenges of cultural and familial obligations while engaging in paid labour. The element of choice is an important consideration in relation to CEs' health. A study by Health Canada [40] demonstrated that choice is a determinant of psychological stress, with greater stress reported amongst those who felt they did not have a choice with respect to their caregiving role (i.e. absence of home care services or cultural expectations to care). In rural areas, such as those in Grand Erie, culturally appropriate homecare services are virtually absent, even though the federal dispersion policies aimed at even distribution of immigrants throughout the country are pushing immigrants to settle in these communities [41]. From the perspective of immigrant CEs' economic, social and health integration, it is essential for stakeholders and government to have an informed discussion about ethnicity and race in the implementation of CFWPs. Otherwise, immigrant CEs may not be having access to supports appropriately tailored to their cultural needs [42].

Relevant to CE's economic, social and health integration, our study findings suggest that more work is needed to address racism, especially in Canadian communities that are predominantly white. Racism is not just a social problem but is an important social determinant of health; it is not a private issue, but rather a systemic problem [43]. Interestingly, as the study findings reveal, even though the European participants shared the social location of 'immigrant', they did not discuss experiences of racism by their white clients/patients.Caragata [44] rightfully asserts that the racial minority members of our society are 'othered', whereas European immigrants are privileged and granted full citizenship based on the commonality of whiteness with white Canadians. We contend that immigrant deskilling and employment discrimination based on race is a form of labour market racism towards certain visible minorities. A denial that racism and discrimination exists in multicultural Canada undoubtedly creates serious policy flaws. Such a denial sends the message that Canada's human rights and multiculturalism policies are adequate "to maintain what most Canadians would describe as a favourable environment for immigrants and minority groups"; further, it disregards the contribution of racism to the lack of immigrant integration and sense of belonging [45].

Conclusions

The continued decline of the welfare state has decreased the availability of government provisions [46] needed to foster CE's economic, social, and health integration. As women integrate formal

and informal care into their work day, neoliberal policies translate their challenges into private and individual issues. Consequently, informal care work "disappears as a public policy" and systemic issue [44], and the needs of female immigrant CE's recede into nonexistence.

Our findings indicate that working multiple shifts negatively impacted immigrant CE's physical, emotional, and mental wellbeing, negatively impacting their sleep, leisure, and sexual life. Future studies need to examine immigrant CE's experiences in the context of transnational care to better understand how they "negotiate the regulation and expectations of two nation states", often complicated by culture,language, and geography given distance and space [47]. As this research, herein has confirmed, we do know that there is very little time and scant resources available to provide care across borders [35,14]. It is thus imperative for service providers to understand the tensions associated with the: cultural and gendered caregiving obligations, and; consequences of transnational caregiving. Further, we need to gather knowledge about different care regimes in order to determine how to best manage the impacts of the multiple shifts immigrant CEs are experiencing. In conclusion, we recognize the limitations of qualitative research and note that the results of this study cannot be generalized to the larger population; nonetheless, in using an intersectionality approach, we see this study as a small step towards providing a holistic understanding of immigrant CE's health.

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