RACIALIZED WORKERS IN WHITE SPACES: EXPLORING THE EXPERIENCES OF RACIALIZED, IMMIGRANT CARE WORKERS IN RURAL AND SMALL TOWN CANADIAN LONG-TERM CARE HOMES

by

Prince Owusu

A thesis submitted to the Faculty of Graduate and Postdoctoral Affairs in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Social Work

Carleton University

Ottawa, Ontario

© 2023

Prince Owusu
Abstract

What are the everyday life experiences of racialized immigrant care workers in rural and small-town Canadian long-term care homes, and how do they navigate white spaces in these contexts? This pre-Covid study centers the experiences of immigrant care workers and describes how they navigate white dominance in rural and small-town Canadian long-term care homes.

The study is timely and provides relevant implications for long-term care homes, pandemic and beyond. While several authors have offered excellent scholarship on long-term care home work and immigrant, racialized workers, the focus has been mainly on urban centers. As a result, little is known about their conditions of work and care in rural and small-town long-term care homes.

My research contributes to extant research by bringing into focus the experiences of racialized care workers in rural and small-towns and demonstrating how white dominance exacerbates poor conditions of work for immigrant care workers. The study utilizes feminist political economy, critical race theory and critical whiteness theory as theoretical foundations, to center their voices in care processes.

The analysis draws on data collected in a sub-study of the Seniors’ Adding Life to Years (SALTY) project, in which rapid team-based ethnographies were conducted in rural and small towns in Ontario, Nova Scotia, and British Columbia. The study analyses white environments and demonstrates how white-settler culture is woven into long-term care spaces, excluding racialized immigrants. Further, it draws on auto-ethnographic stories from my experiences as a racialized immigrant in the research field and stories from immigrant care workers to explain processes of racialization in long-term care home settings. Parsing out the implications of the casualization of long-term care home labour and burdensome credential validation processes, the study demonstrates how immigrant care workers are set up to experience the most precarious conditions of work in long-term care homes.
Acknowledgements

Thank you is an underestimation of the gratitude I owe my supervisor, Susan Braedley, who has contributed immensely to my development as an academic. For the incredible amount of patience that has challenged the very limits of her patience, I am grateful.

To my committee, I say a big thank you for shaping my ideas from the onset and for challenging me to do better. Thank you, Colleen Lundy, Lisa Mills, and Paul Mkandawire.

My sincere gratitude to the Seniors Adding Life to Years (SALTY) principal investigator, Janice Keefe, and the entire team. Special thanks to the sub-study team for the incredible support during site visits. Your formal and informal conversations, thought-provoking questions, and genuine interest in my study made a huge difference for me. I am highly indebted to you, Tamara Daly, Ivy Bourgeault, Katie Aubrecht, Jacqueline Choiniere, Vasuki Shanmuganathan, Susan Braedley, Pat Armstrong, and Hugh Armstrong. You accepted me and taught me what it means to be a team.

Thanks to my family, especially my mother, Felicia Owusu, for all the emotional support throughout this journey. To my church family, I say thank you. Denise and Allen Macartney, thanks for your mentorship, compassion, and generosity. To Elizabeth Reibin, who would always cut articles from newspapers for me, and Grace Atanga, Gifty Adom, and Elaine Ngwa, who told me many stories about their encounters in long-term care homes, I am grateful.

Now to Akosua, Nyamekye Owusu, my daughter, who was given no choice in sacrificing her developmental years for this project, I say thank you.
Dedication

I dedicate this dissertation to immigrant care workers, many of them women, who have sacrificed before and throughout the COVID-19 pandemic, and some of whom have succumbed to the virus. To those who have passed at the frontlines, may your memory live on, and to those who continue the struggle at the frontlines, finding joy, shedding tears, and making a living - You are true heroes.
# Table of Contents

Abstract .................................................................................................................. ii  
Acknowledgements ................................................................................................ iii  
Dedication ............................................................................................................... iv  

Introduction: Setting the Stage ........................................................................... 1  
  Immigrant labour: Why it matters and why all of us should care ...................... 4  
  The Research Project ........................................................................................ 8  
  Reflexivity ........................................................................................................ 10  
  Thesis Statement ............................................................................................... 11  
  Organization of the Study ............................................................................... 13  
  Concluding Thoughts ...................................................................................... 16  

Chapter 1: Theoretical Framework .................................................................... 17  
  Feminist Political Economy ........................................................................... 17  
  Critical Race Theory ....................................................................................... 21  
  Critical Whiteness Theory ........................................................................... 25  
  Centered in Policy, Marginalized in Practice: Charting the Contours of Immigrant Care Work ......................................................... 28  
  Immigrant Care Work .................................................................................... 30  
  Coercion ......................................................................................................... 32  
  Conditions of Work ....................................................................................... 34  
  Whiteness ....................................................................................................... 36  
  Overt and Covert Racism ............................................................................... 38  
    Social Class .................................................................................................. 42  
  Concluding Thoughts .................................................................................... 43  

Chapter 2: Critical to Care: The Conditions of Work for Racialized Immigrant Care Workers in Canada ................................................................. 45  
  Racialized Immigrant Care Workers: Creating a Long-term care Labour Force ............................................................................................. 46  
  Working Conditions in Canadian Long-term Care Homes ............................. 50  
    Shift Work .................................................................................................... 52  
    Staffing Levels, Skill Mix, and Divisions of Labour ....................................... 52  
    Structural Violence, Racism, Sexism and Xenophobia on the Job ............... 54  
  Whiteness and Racialization in Institutional Settings ...................................... 56
Concluding Thoughts ........................................................................................................... 61

Chapter 3: The Policy Context for Immigrant Long-term Care Work in Canada: Nova Scotia, Ontario, and British Columbia .................................................................................... 63

The Nova Scotia Context ...................................................................................................... 65
  Overview ........................................................................................................................... 66
  The Long-term care Policy Context in Nova Scotia ........................................................... 66
  The Immigration Policy Context in Nova Scotia ............................................................... 69
  Nova Scotia’s Long-term care Union Activity Context ....................................................... 70

The Ontario Context ........................................................................................................... 71
  Overview ........................................................................................................................... 71
  The Long-term care Policy Context in Ontario ................................................................. 72
  The Immigration Policy Context in Ontario ................................................................. 75
  Ontario’s Long-term care Union Activity Context .......................................................... 76

The British Columbia Context ............................................................................................. 77
  Overview ........................................................................................................................... 77
  The Long-term care Policy Context in British Columbia ................................................ 78
  The Immigration Policy Context in British Columbia ..................................................... 79
  British Columbia’s Long-term care Union Activity Context ........................................... 81

Concluding Thoughts ......................................................................................................... 82

Chapter 4: Project Design and Methodology ..................................................................... 83

How I Situate my Research ................................................................................................. 86

Methods ............................................................................................................................... 87
  Data Collection Methods ................................................................................................. 88
  Entry Strategies ................................................................................................................. 90

Study Sites .......................................................................................................................... 91
  Ontario Study Sites ........................................................................................................ 93
  Nova Scotia Study Sites .................................................................................................. 95
  British Columbia Study Sites ........................................................................................ 96

Study Participants ................................................................................................................. 98
  Management Interviews ................................................................................................. 100
  Field Notes ..................................................................................................................... 100
  Data Analysis ................................................................................................................ 101
Concluding Thoughts ........................................................................................................... 103
Chapter 5: Working in White Environments ........................................................................ 104
Picture Analysis: A Portrait of Whiteness ........................................................................ 105
Long-term Home Care (Home for Whom?) ........................................................................ 106
  Food .................................................................................................................................. 107
  Physical space .................................................................................................................. 109
  Race, Racialization, and Culture ..................................................................................... 110
Promising Alternatives ........................................................................................................ 114
Whiteness and Space: Unpacking Meaning .................................................................... 114
Concluding Thoughts ........................................................................................................ 117
Chapter 6: Real People, Real Stories, Real Lives Stories ..................................................... 118
  Making Choices: Juggling the Dimensions of Precarity .................................................. 119
  Chilly Climate: “All I want is tolerance” ........................................................................ 122
  Immigration, Loneliness, and Social Isolation: Long-term Care Work as a Place of Solace
  ........................................................................................................................................... 126
  Immigrants as Natural Caregivers? “Just like back home” ............................................. 128
  Consciously Unconscious: A Tale of the White Gaze ..................................................... 130
  Immigrant Caregivers, Different Voices, One Story ....................................................... 133
Concluding Thoughts ........................................................................................................ 135
Chapter 7: It’s a Set Up! The Experiences of Racialized Immigrant Care Workers in Long-term
Care ........................................................................................................................................ 136
  Dimensions of the Set-up: Precarious Life Conditions, Precarious Work ................... 137
  Violence ............................................................................................................................ 142
  Covert Racism ................................................................................................................ 150
  Culture Shock .................................................................................................................. 152
  Certification Process ....................................................................................................... 153
Coping and Resistance .......................................................................................................... 156
  Teamwork ........................................................................................................................ 158
  Resisting through Care ................................................................................................... 160
  Strategic Permanent Residence, Family Reunification, and Support ............................ 163
  Inviting friends to Work in the Sector ............................................................................. 167
Humour ............................................................................................................................... 169
<table>
<thead>
<tr>
<th>Concluding Thoughts</th>
<th>170</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 8: Towards Equitable Labour Processes</td>
<td>171</td>
</tr>
<tr>
<td>Implications for Research, Policy, Feminist Political</td>
<td>179</td>
</tr>
<tr>
<td>Economy and Social Work</td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>180</td>
</tr>
<tr>
<td>Policy</td>
<td>182</td>
</tr>
<tr>
<td>Racism at Work and Feminist Political Economy</td>
<td>185</td>
</tr>
<tr>
<td>Conclusions</td>
<td>189</td>
</tr>
<tr>
<td>So What?</td>
<td>191</td>
</tr>
<tr>
<td>References</td>
<td>197</td>
</tr>
</tbody>
</table>
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Introduction: Setting the Stage

This dissertation explores the experiences of racialized immigrant care workers in long-term care homes situated in rural areas and small towns in Canada. At the heart of the dissertation is an implicit contradiction in the Canadian care economy. Canada positions itself as a welcoming state, inviting immigrants through diverse programs into its care economy, yet racialized immigrant care workers are forced to navigate oppressive work organizations, processes, and environments without support (Atanackovic and Bourgeault, 2013; Syed, 2020). These challenges are accentuated in rural and small towns where racialized care workers have no respite in the form of familiar neighbourhoods or communities. Additionally, the everyday life experiences of racialized immigrant care workers, who navigate and continually feel "othered" both inside and outside of their paid work, are distinct from those of white-settler and established racialized workers while also having some conditions in common.

Like many other kinds of work in the care economy, long-term care work is precarious work for many reasons, as this dissertation will explain (Lowndes and Struthers, 2016; Syed, 2020), and workers at the frontlines feel the brunt of the poor working conditions. For racialized care workers, these poor working conditions are exacerbated by their subordination within an undervalued and overlooked gendered care economy.

This study is timely as the Covid pandemic has exposed long-standing challenges in the care economy (Armstrong and Armstrong, 2020; CIHI, 2020a; Clarke, 2021). There has been increasing policy interest in facilitating the immigration of skilled workers to fill health care and long-term care labour shortages but without policy attention to the systemic inequities these workers face in Canada (Ramesar, 2021). Though data for this study was collected pre-Covid, it
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

is perhaps even more relevant in the post-Covid case as the questions the dissertation poses remain unresolved, and the need for care workers has increased during and after the pandemic.

This study seeks to explore the everyday experiences of racialized immigrant care workers in the obdurately white work environments of long-term care homes in Canadian small towns and rural areas and to understand how white dominance impacts precariously situated immigrant care workers. The research context adds to the relevance of the study because, beyond the general lack of research on the experiences of racialized immigrant care workers in long-term care homes, very little is known about those in rural and small towns. To fill this lacuna in extant research, the study advances these two questions:

1. What are the everyday life experiences of racialized immigrant care workers in rural and small-town Canadian long-term care homes, and what implications may this have for the conditions of care for residents?

2. How does white dominance operate in these publicly funded institutions? What dimensions of white dominance do we see at work in long-term care homes? How does it affect racialized immigrant care workers in this sector?

These questions are pertinent because Canada continues to struggle with acute shortages of workers in its care economy, a situation worsened by the pandemic. Now more than ever before, there is a growing demand for immigrant care workers, most of whom come from the Global South or the Caribbean. Cornelissen (2021) shows through the 2016 census data, and the longitudinal immigration database that adult immigrants from the Caribbean and Bermuda (13%), Western Africa (12%), Central Africa (12%), Eastern Africa (8%), and Southeast Asia (10%) are overrepresented in nursing or healthcare support occupations in Canada.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Yet, these care workers are coerced to conform to long-term care homes that were designed without consideration for their presence. They are often pressured to work in the lowest-paid positions that are considered to require lower skill levels. Additionally, they are subjected to poor working conditions that are prevalent in the industry. Deplorable conditions in long-term care homes reflect back on Canadian society, on how it treats newcomers, those in front-line care jobs, and its most vulnerable population of frail, disabled, and older people. Further, creating equitable working conditions where workers can labour with dignity and respect is instrumental to improving the conditions of care in long-term care homes.

The research questions also bring into focus the precarious conditions under which racialized immigrant care workers labour and their location in white environments in long-term care homes. To address them, I follow the example set by Yancy (2008, 2012, 2015) to flesh out the lived experiences of race and carefully describe how they unfold in everyday social encounters. Here, I tease apart the simultaneous ubiquity and evasiveness of whiteness as it permeates all aspects of long-term care homes. To achieve this goal, I focus on:

1) representation: to understand how the presence and absence of racial and cultural markers in long-term care homes tell us something about white dominance, and

2) policy: to understand how credentialization and casualization of the long-term care home sector serve to limit and coerce racialized immigrant care workers into the lower echelons of the long-term care home work hierarchy, and

3) everyday encounters of racism: to understand how racialized care workers navigate microaggressions on the job.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

These areas of focus are interrelated and complex and explicate the precarious positions of immigrant care workers and how those positions are sustained by white dominance.

This project aims to give voice to oppressed racialized immigrant care workers who have little or no voice or recognition outside the jobs they perform in long-term care homes. Drawing on ethnographic field work conducted between 2017 and 2019, this dissertation goes some way to explain how these workers’ experiences are connected to their policy context and conditions of work. In what follows, I explain the crux of the problem under study, explain how my study was conducted as part of a broader study and reflect on my positionality. I then provide a thesis statement to clarify the focus of the study, after which I explain how the study was organized.

**Immigrant labour: Why it matters and why all of us should care**

This dissertation focuses on the working conditions and experiences of racialized immigrant women (and some men) employed in long-term care homes situated in small towns and rural communities in Nova Scotia, Ontario, and British Columbia, Canada. While the number of racialized immigrant care workers in the Canadian care economy is increasing (Armstrong and Braedley, 2013; Block and Galabuzi, 2011; Houle, 2020; Turcotte and Savage, 2020), the voices of these workers are silenced both in policy and in everyday life (Syed, 2020), and perhaps most acutely in areas of Canada where racialized populations are a smaller proportion of the population. For many racialized immigrant care workers, the complexities of their immigration status and the experiences of racism in both overt and covert forms further marginalize them and exacerbate the poor conditions under which they work (Braedley et al., 2018; Syed, 2020).

These experiences are rooted in a long history of systemic racism, exclusion, and exploitation of racialized immigrant workers (Choudry and Smith, 2016). Canada as a settler-colonial state
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

(Coulthard, 2014), has repeatedly enacted discriminatory policies which have adversely impacted immigrants. The Chinese head tax, the Japanese internment camps, and the deplorable conditions in home care under the live-in-caregiver program are examples (Leah, 1999). Again, the enactment of strict credentialization policies that funnel overqualified immigrant care workers into lower occupational levels is an example of such discriminatory policies.

Despite the fact that many immigrants come to Canada with training in health care occupations and professions such as nursing, strict professional credentialing policies for health care work in Canada often require additional education and Canadian experience that is both expensive and difficult to acquire (Nourpanah, 2019a). These policies mean that immigrants are clustered in lower-paid and lower-skilled occupations in long-term care homes, including nurse aides, orderlies, and patient service associate occupations (Cornelissen, 2021), shaping a gendered, racialized division of long-term care home labour that places many racialized women immigrant care workers at the bottom of the work hierarchies (Banerjee et al., 2015; Braedley, 2018; Syed, 2020).

The non-recognition of foreign credentials institutes employment discrimination and helps in producing the systemic exploitation of racialized immigrant care workers. These policies systematically deskill many racialized immigrants care workers, compelling them to work with higher competencies at lower skill levels doing some of the most precarious jobs (Syed, 2020). That notwithstanding, racialized immigrant care workers continue to work their hearts out and are often grateful for the opportunity to work in the Canadian care economy. Through this work, they support their families inside Canada and send remittances to their families outside Canada. It is right here that the chasm is uncovered. The Canadian care economy needs racialized
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

immigrant care workers, yet they are treated inequitably within an oppressive, gendered, and hierarchically ordered long-term care sector.

Long-term care homes evoke images of loss, chronic illness, suffering, multiple comorbidities, and frailty, as well as concerns about quality of care (Sussman and Dupuis, 2012; Rodriguez, 2014; Lowndes and Struthers, 2016). In Canada, long-term care includes a range of services provided in a care continuum, ranging from home care, community-based systems of support, supportive or assisted living, and facility-based care (CIHI, 2020). Facility-based care, commonly referred to as a long-term care home or a nursing home, is the focus of this dissertation. These facilities provide medically necessary and personal care to individuals who are unable to live in their homes or communities because of the multiple comorbidities they live with (Canadian Health Coalition [CHC], 2018). They provide 24-hour support and accommodation for residents, including nursing services, physician services, assistance with activities of daily living, behavioral therapy, and other professional and ancillary services (CHC, 2018). The care provided in long-term care homes is nested in social relations that are as important as the care delivered around the clock.

The social relations produced by the employment of racialized immigrant care workers in long-term care homes are particularly important and worth investigating because they are embedded in systemic discrimination. It is necessary to ensure that workers are treated with fairness and respect and given a work environment that is equitable. Again, the social interactions that arise from systemic discrimination can worsen the already difficult working conditions that all employees encounter while caring for residents, as highlighted by Cottingham, Johnson, and Erickson (2018). Decent care is likely to emerge organically where there are decent working conditions. When workers earn a decent wage under dignified conditions of work, they can expend their best toward
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

the work they do and the people with whom they interact. As Armstrong, Armstrong, and Choiniere (2015) succinctly put it, “the conditions of work are the conditions of care” (p. 19).

Apart from the social locations of immigrant care workers, another point worth noting is the environments within which they work and live (Salami and Nelson, 2014). Racialized care workers work in many white-settler communities and neighbourhoods with cultures and values far removed from their experiences, especially in rural and small towns where racialized workers are fewer in number both on the job and in the community. They are likely to have little opportunity to interact with those who share their culture, language, faith, and traditions. Immigrant care workers often struggle to navigate these white spaces and assert themselves, as they have little or no respite from white spaces in the form of associations and communities from their home country or linguistic, faith, or cultural communities. This is worse for those experiencing some form of family separation, whether temporary or permanent, resulting from their immigration to Canada (Strauss and McGrath, 2017).

It is pertinent to note that whiteness as a characteristic of these environments is not the main focus of this dissertation. Rather, my focus is on whiteness as a form of dominance in terms of culture, values, and policies that exist within and outside long-term care homes and how racialized care workers traverse those environments. Here, my interest is to tease out whiteness as a social relation of colonial racism, to explore the interactions between whiteness as a characteristic of long-term care home environments and culture in Canada and the experiences of racialized care workers, and to bring attention to the considerable contributions these workers make to the long-term care home sector.
Although this study was conducted pre-pandemic, it is pertinent to the Covid-19 and post-Covid context, especially because of the renewed interest in the recruitment and retention of racialized immigrants for long-term care home work. In Canada in 2016, the number of individuals employed as nurse’s aides, orderlies, and patient service associates was 245,500, and out of these workers, 87,925 were immigrants, accounting for more than a third of the total number (Turcotte and Savage, 2020). The number of these workers has continued to rise over the years (Estabroooks et al. 2020), particularly because of the acute shortages driving the demand for immigrant care workers (Ramesar, 2021).

The findings of this research add to existing knowledge on the impact of working conditions on the lives of racialized immigrant care workers, residents, families, and other stakeholders to generate promising practices to inform policy changes. Further, the significant and rapidly increasing racialized population of Canada, including racialized care workers themselves, are also aging but are yet to be welcomed in a culturally safe way in publicly funded long-term care homes, as these spaces are obdurately white. The overwhelming majority of long-term care residents are from white-settler groups, and much will need to change to appropriately serve the next generations of older adults in Canada. Finally, it is important to create long-term care homes and communities which center the experiences, cultures, and contributions of immigrant care workers and pivot from merely considering them for the labour they provide.

The Research Project
I was supported to independently develop and conduct this study under the umbrella of a CIHR-funded project led by Dr. Janice Keefe (Mount Saint Vincent University), Seniors Adding Life to Years (SALTY). I was a team member and trainee in a “rapid team-based ethnography” (Armstrong
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

and Lowndes, 2018) sub-study of this large-scale project, co-led by Dr. Tamara Daly (York University) and Dr. Ivy Bourgeault (University of Ottawa). This sub-study team collected data in purposively selected long-term care homes in four provinces to investigate questions on relational approaches to care. Relational approaches to care foster interpersonal care relationships that are important for the delivery of care in a compassionate and dignifying way for residents. Details of the approach and my role on the SALTY sub-team are provided in Chapter four of the dissertation. Generally, my role on the SALTY sub-team involved the design and refinement of research interview guides, application of ethics at Carleton University’s Research and Ethics Board, debrief meetings and field research.

For my independent analysis in this dissertation, I used six ethnographic data sets collected by the team, including two sets from purposively selected long-term care homes situated in small towns and rural areas in three provinces (Ontario, Nova Scotia, and British Columbia). The process of my analysis is fleshed out in Chapter 4 of the dissertation.

These provinces present interesting case studies of race, immigration, and long-term care work. First, Ontario has the most long-term care beds in Canada and the highest number of racialized workers in long-term care (Turcotte and Savage, 2020; CIHI, 2020a). Nova Scotia is particularly interesting because it is seeking to overhaul its long-term care policy and has become a destination for racialized care workers with the introduction of the Atlantic Migration Program and other recruitment policies pitched toward skilled immigrants (Hande and Nourpanah, 2022). British Columbia, and particularly some of its rural and small-town areas, is regarded as the retirement destination of Canada because of its beauty and good weather (Longhurst, 2017), and it has a significant and growing population of immigrants from Pacific Rim countries. These three contexts
are distinct but also share many similarities in terms of long-term care policy and workplace culture. They also provide a rich context for exploring the dissertation’s research questions.

**Reflexivity**

To get at the research question in a meaningful way as a Black man with temporary migration status who is racialized in Canada, I utilized a critical reflexive approach to unpack my experience of the research process in order to implicate myself fully in the process as well as resist oppressive elements embedded in the research process.

As a racialized man, I entered the research space and process, cognizant of my body and identity and what my presence alone evoked. The loudness of my presence meshed sharply with the silence and invisibilization that I felt in the research field in ways that are almost inexpressibly defined. As a Black man in this research space, I acknowledged the privilege of being in this space, yet I was intimately aware of the gazes that stared as I trudged on this stage. Being Black is a permanent marker of my identity, one that structurally positions me in an underprivileged place in life. Yet I consistently struggled to mobilize my strengths to fight for social justice for those with whom I share this structural oppression. This project is crucial to my quest for social justice. As a Black researcher, I am aware that I must continually fight for legitimacy to assert myself and the contributions I make as relevant.

Historically, research was utilized as an oppressive framework to advance the interests of imperial forces in the colonial project (Smith, 2021). Many marginalized communities continue to experience research as an oppressive framework that puts their lives under scrutiny. For racialized immigrant workers who are being oppressed in unresponsive institutional frameworks that value their labour and not their person, research must be meticulously carried out collaboratively with
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

workers. In this research, the tension among racialized workers was palpable - a formidable wall that was sometimes broken after an elaborate explanation of the reason why their voices were pertinent to the project.

Conclusively, as a Black feminist political economist and a social worker trained in structural social work, I brought myself to this project in ways that allowed me to get at research questions both experientially and collaboratively with research participants. I was also intentional about creating space to listen in humility to connect deeply with participants. In rural and small towns, there were few racialized workers traversing these white environments and neighbourhoods. Their experiences were unique and were explored in-depth in the dissertation. Being a Black researcher in predominantly white institutions was telling, and affectively I could tap into the feelings of racialized care workers in those institutions.

**Thesis Statement**

Despite the pertinent contributions of immigrant care workers in the Canadian care economy, they are precariously situated in rural and small-town Canadian long-term care homes, which are obdurately white and detached from their culture. This exacerbates the already deplorable conditions under which they work.

In Canada, the challenge of maintaining an adequate labour force in the long-term care sector has been amplified by demographic aging and concerns about escalating healthcare demands. As a result, immigration has been considered a crucial solution. Racialized immigrant care workers have become a more readily exploitable labor force compared to Canadian-born individuals and white workers due to limited alternatives. Immigrant care workers play a vital role in Canada's care economy, particularly in long-term care homes, but they face significant challenges due to
their precarious position in predominantly white, culturally detached environments. This problem is compounded by a severe shortage of workers in the care economy and the resulting high demand for immigrant care workers, exacerbated by the pandemic.

Drawing on the 2016 census of population and longitudinal immigration database, Cornelissen (2021) asserts that adult immigrants are overrepresented in nursing and health care support occupations. The majority of these immigrant care workers are women, despite a growing number of men. In rural and small-town long-term care homes, immigrant care workers navigate racialization and racism at work when they are othered and discriminated against (Braedley et al., 2018). These concerns worsen the existing poor conditions of work for immigrant care workers and add a complex layer of work-related stress. On top of that, immigrant care workers often occupy low-wage positions within the workplace hierarchy that do not reflect their qualifications and experience, as their credentials are not recognized in Canada. These low-waged positions are considered low-skill and are poorly remunerated. Immigrant care workers continue to bear the gendered impacts of care labor, as care work is undervalued, underpaid, and primarily associated with women. Additionally, immigrant care workers navigate workplaces that are distinct from their culture, language, and traditions. They are recruited to fit in the Canadian care economy without recourse to their social location and culture, which impacts their everyday life and work. Recognizing the intricate complexities of the experiences of immigrant care workers, the dissertation explores these experiences in care homes and envisions a future in which immigrant care workers are treated equitably and valued for their contributions.
Organization of the Study

The dissertation is organized into eight main chapters. The study begins with an introduction that fleshes out the context of the study and how racialized care workers are situated in rural and small-town long-term care homes. Following the introduction, the first chapter elucidates the theoretical frameworks and concepts deployed in the study. The goal here was to ground the dissertation in theories that address the research questions and align with my political commitment toward social justice. Concepts that anchor the study are unpacked and operationalized for the purpose of the study.

Next, the dissertation reviews extant literature on long-term care homes in Canada and identifies gaps the study seeks to fill. The review of literature focuses on working conditions and whiteness as a characteristic of long-term care homes. The next chapter compares long-term care home policies and practices across three study sites in Nova Scotia, Ontario, and British Columbia. This part of the study provides a snapshot of the policies and practices which shape each study context and outlines activist initiatives that point to systemic issues with which each province is contending. As labour is central to this dissertation, the chapter reviews union advocacy positions across the three provinces as well.

In the chapter that follows, the study transitions to discussing the project design and methodology. The chapter details how the dissertation was situated in another study and the advantages and disadvantages that emerged. Also, I reflect on my positionality and how that informs the way I approached the study in general. The methods of the study are discussed in detail in this chapter.

The next three chapters discuss different facets of findings from the study. The first facet of findings focuses on white environments in long-term care homes, the second explores stories from
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

the study, and the final facet reviews findings from interviews with racialized care workers, linking them to extant literature and mapping out connections to conditions of work, violence, coping, and resistance. These findings inform the implications outlined for research, policy, and feminist political economy and the conclusion and recommendations in the final chapter.

Furthermore, in my findings chapters (five, six, and seven), I diverted from typical approaches to political economy analysis by working with my data to incorporate and develop a more interpretive analysis that includes storytelling, a poem, and reflexive first-person accounts of my research journey. While vestiges of my colonial training in Ghana and my concerns about how my work will be received by more mainstream-oriented healthcare policy researchers are evident in how I write and present this work, I have taken courage and inspiration from those academics, including feminists, Black feminists, Indigenous scholars, and more, who push back and resist colonial knowledge by incorporating embodied, emotive knowledge into their political, economic, and social analysis. Ethnography allows for this approach, and field notes were particularly important to it, requiring me to reflect and then consider and analyze my reflections.

The dissertation’s analysis chapters begin with Chapter five, in which I draw on both field notes and an analysis of photographs taken on research sites by the SALTY stream 2 team, to describe how whiteness permeates these long-term care home environments, simultaneously “othering” and invisibilizing racialized workers. Photographs in this study were taken on research sites as aide memoires to help researchers ensure that analysis kept the physical environment in mind, helping us to corroborate and triangulate findings. As this analysis was not anticipated, our ethics review does not permit me to include photographs in this dissertation, as they could identify the homes
included in this study. Given the layers of ethics review involved in this project at five universities and two health authorities, gaining permission was not possible.

Next, in Chapter Six of this dissertation, I begin the analytic sections of this dissertation with stories I developed from my experiences in the field as a racialized man, grounded by feminist political economy and critical race theory. Critical race theory offers a theoretical grounding for my analysis and interpretation of the stories. Feminist political economy centered my analysis of the social relations that both shape and emerge from the stories. The emphasis on experiential knowledge of people of color by critical race scholars (Gillborn, 2015) provides the theoretical backing for highlighting and parsing out the stories. As Delgado and Stefancic (2017) note, the “unique voice of color” tenet of critical race theory posits that oppressed writers are better positioned to communicate issues of oppression and resist systemic racism because of their lived experience.

Again, I draw on the work of Yancy (2008, 2012, 2015) to frame my analysis of the stories I present here. Yancy (2015) developed a writing style where words become flesh as he unpacks the “lived existential dynamics of race” (pg, xi). In doing so, his goal is to bring readers closer to the feel of racist real-world encounters in all their messiness. Race and racialization are performed in everyday practices within embodied spaces of social relations (Yancy, 2015). My goal as I draw on the work of Yancy is to explore these embodied social relations through stories that place emphasis on white dominance in complex social relations and how exploitative and oppressive their machinations are on the lives of racialized care workers. Yancy (2008) himself uses vignettes to explore racist encounters in his book “Black bodies, white gazes”. His model of analysis serves as a frame for the discussion of stories in Chapter 6 of the dissertation.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

In Chapter seven, I develop an analysis of interviews with racialized care workers focusing mainly on their experiences on the job and the structural challenges they navigate. I analyze how the structural challenges set them up for exploitation in care homes and how they utilize their agency in resisting oppressive working conditions.

**Concluding Thoughts**

There is a clear contradiction when Canada’s immigration policy strategy is juxtaposed with the working conditions created for immigrant care workers in its care economy, particularly in long-term care homes, as described in this study. Globally, Canada is regarded as a model for streamlining immigration policies to align with economic priorities, including the care economy, yet the struggle to integrate immigrants equitably continues unabated.

While Canada is globally recognized as a country that welcomes immigrants into its economy and social fabric, immigrants face several challenges, including discrimination and inequitable working conditions when they enter Canada. This study seeks to describe the everyday life and work experiences of immigrants in rural and small-town long-term care homes, with data drawn from three provinces (Nova Scotia, Ontario, and British Columbia), in the SALTY project.
Chapter 1: Theoretical Framework

To explicate the value placed on care work and by extension immigrant care work, and to call attention to capitalist colonial machinations that orchestrate the continued exploitation and disposability of racialized care workers, I draw on feminist political economy, critical race studies, and critical whiteness studies. Together, these theories do not merely clarify the social relations that emerge from capitalist exploitation but also recognize the resilience and agency of oppressed subjectivities - in this case, immigrant care workers. Though the three theories utilized in the dissertation have their distinct foci, they share commitments to unmasking structures of power, resisting oppression, and fighting for social justice. Additionally, the theories complement one another because all were developed with pertinent contributions from feminist materialist theorists (Delgado and Stefancic, 2012). I draw on critical race theory and critical whiteness theory to provide a more robust and complex theorization of race than is offered by most feminist political economy analyses. In what follows, I review the philosophical positions and core tenets of feminist political economy, critical race theory, and critical whiteness theory. Subsequently, I address the pertinence of these theories in my study.

Feminist Political Economy

I draw on feminist political economy in the dissertation because it provides analytic categories that flesh out paid and unpaid care work as they emerge in material and social relations (Luxton, 2006; Braedley and Luxton, 2015). Feminist Political Economy (FPE) is an interdisciplinary field that seeks to understand the relationship between the social relations of gender, race, and class, and political economy. FPE scholars use feminist theories to analyze the ways in which economic structures and policies produce and maintain gender inequalities and to propose alternative policies that promote equitable social relations.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

One of the central contributions of FPE is the analysis of the gendered impacts of political and economic policies and practices. FPE scholars have argued that neoliberal policies such as privatization and deregulation have disproportionately affected women and other marginalized groups (Fraser, 2016; Chant and Sweetman, 2012). FPE has also been used to analyze the gendered impacts of trade policies and global value chains, which have often led to the exploitation of female workers in low-wage industries. Feminist Political Economists argue that such processes are not gender-neutral but rather are shaped by intersecting forms of social inequality. For example, feminist scholars have shown how race and class intersect with gender to produce unique experiences of economic marginalization for women of color (Collins, 2000). Similarly, FPE has contributed to an understanding of how the global economy operates through unequal power relations between the Global North and South, as well as between men and women (Elson, 1993).

Another key theme in FPE is the analysis of unpaid care work and its relationship to gender inequality. FPE scholars have argued that the gendered division of labor in the household, which assigns caregiving responsibilities to women, is a key driver of gender inequality in the labour market (Bakker and Silvey, 2008). FPE has also been used to analyze the ways in which public policies, such as social welfare and child-care programs, can support women's labour force participation and reduce gender inequalities (Daly and Rake, 2003). Whether in the household as unpaid familial work or as paid work in a nursing home, the necessary care work involved in looking after frail, ill, and disabled people is mostly done by women and is undervalued, even taken for granted. The gendered division of labour that assigns care to women has implications for material and social relations as well as women’s social and political positions. Feminist political economy draws attention to these positions and locations within and across history (Arat-Koç, 2006; Luxton, 2006; Braedley and Luxton, 2015). Feminist political economists have long noted
that the undervaluation of care work is central to women’s oppression, particularly for migrant women involved in care work in host countries (Glenn, 2010; Armstrong and Braedley, 2013; Braedley and McWhinney, 2022). Many migrant women navigate double jeopardy in relation to their positions in the care economy for two main reasons. First, care work is gendered, undervalued, and underpaid because it is constructed as natural to women in familial relationships (Glenn, 2010). Second, because of the transcending impacts of colonialism, racialized people under capitalist neoliberalism have been oppressed and treated as disposable.

Feminist political economy uses gender, race, and class as analytic tools to unpack material and social relations in everyday life. These analytic categories “interact with, contest, and reinforce” each other (Baines, 2001, p.6). Paid and unpaid care work overlap in ways that are gendered, classed, racialized, and normalized in political, economic, and social structures (Glenn, 2010; Braedley and Luxton, 2015). Feminist political economists have drawn attention to the political, economic, and social ideals that sanction these material relations and lead to the oppression of care workers. The interactions among gender, race, and class are important in feminist political economy analysis because they clarify commonly taken-for-granted assumptions about labour processes. In feminist political economy analysis, gender, race, and class are interconnected and mutually constituted and create overlapping forms of privilege and oppression. FPE recognizes that women’s experiences are not homogenous but vary depending on race, class, and other important intersecting identities. For example, working-class white women may face gender-based discrimination at the workplace but still enjoy some privileges associated with their race, whereas working-class racialized immigrant women may experience racism and economic marginalization in addition to gender-based discrimination. Paying attention to the intersection of gender, race, and class allows us to recognize the economic marginalization that worsens the experiences of women
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

of color (Collins, 2000). Immigrant care workers’ positions and locations in the care economy are not just about the labour they are involved in but also about power, oppression, domination, and capitalist exploitation. It is these entangled relations that this dissertation seeks to flesh out in productive ways.

Social reproduction is a core concept of feminist political economy (Braedley and Luxton, 2015). Social reproduction is the socially necessary mental, physical, and emotional work involved to “maintain existing life and to reproduce the next generation” (Luxton, 2006, p.36) for the working classes. Arat-Koç (2006) was among those who pointed out that many migrant women engage directly in the social reproduction of the host country’s population by working as “maids, nannies, or caregivers for the elderly or the disabled, or as sex workers” (p.77). Many high-income countries depend on the undervalued and unpaid care work performed by immigrant care workers (Braedley and McWhinney, 2022). Fleshing out the key assumptions that shape social reproduction as an entry point in feminist political economy analyses, Braedley and Luxton (2015) note that sex/gender divisions of labour are not natural, but historically and socially constructed and change over time; the activities in sustaining and reproducing daily life are not just biological or instinctive expressions of the way people naturally live in families, but constitute work that is determined by regional historical, political, economic, and social relations; these labors are not just private activities involved in intimate kinship and family relations but work that is socially necessary and central to the production of both subsistence and wealth in any society (p. vii).

With the heightened realities of the COVID-19 pandemic and beyond, social reproduction has been recognized as fundamental to our livelihoods. Further, its potential to build solidarity across movements that stand against capitalist oppression cannot be underestimated (Armstrong and
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Armstrong, 2020; Braedley and McWhinney, 2022). Specific to this study, the concept of social reproduction allowed me to understand how racialized immigrant care workers in rural and small-town Canadian long-term care homes are inserted in the care economies of Canada and elsewhere in three main ways. First, they are involved through their work in long-term care homes, caring for frail, ill and disabled working-class people who need it. Second, they are involved through reproducing themselves and members of their households every day and through bearing and caring for the next generation in their families. Finally, they are involved through their work to support the reproduction of families and communities in their countries of origin via wages paid out as remittances and all kinds of support, from online calling to visits and more. These workers are social reproduction super-producers upon whom so many lives rely.

Critical Race Theory

While feminist political economy considers race as a social relation, it has not emphasized or critically assessed systemic racism. Because of the pertinence of race to my dissertation, I draw on critical race theory to provide a robust analytic entry point and a solid interrogation of race in this dissertation. As a theoretical framework, critical race theory (CRT) exposes racism in society and more directly challenges racial prejudices embedded in power structures, law, culture, and society (Delgado and Stefancic, 2012). Although the term CRT developed in the early 1980s as an intellectual response by legal scholars who sought to scrutinize and expose racial prejudice and colorblindness in law and social structures (Crenshaw, 2019), the foundations of the theory can be traced to the work of W.E.B. Du Bois (1903/1989) who exposed the systemic equities and exclusion experienced by African Americans. W.E.B. Du Bois, a pioneering African American sociologist, Black nationalist, and civil rights activist, was instrumental in the development of CRT. His work contributed to the development of the concepts of race, racism, and racial
inequality in American culture, providing the groundwork for a critical examination of race that has shaped contemporary scholarship (Delgado and Stefancic, 2017). One of Du Bois’ (1903) fundamental contributions to CRT was the concept of ‘double consciousness’. Du Bois (1903) outlines how African Americans traverse a duality of identity, continually negotiating their sense of selfhood within a racially unjust society in his book ‘The Souls of Black Folk’. This notion emphasizes the psychological and social implications of racism, emphasizing marginalized racial groups’ lived experiences and internal tensions.

Another concept developed by Du Bois (1903), which became a focal point of CRT analysis is the ‘colour line’. He contended that racial divides and hierarchies were a basic line of demarcation in American culture, sustained by discriminatory legislation and social practices (Du Bois, 1903). This concept questioned the prevalent idea of racial equality and served as a foundation for investigating systemic racism and its consequences on marginalized populations. Du Bois also undertook empirical research to demonstrate racial disparities and the structural roots of racial injustice. "The Philadelphia Negro" (1899), his fundamental sociological study, studied the socioeconomic realities and living experiences of African Americans in Philadelphia, presenting a critical examination of the social, economic, and political issues they faced. This empirical technique cleared the way for future CRT researchers to explore institutionalized racism and its impact on other aspects of society, such as education, criminal justice, and healthcare.

Another central tenet of CRT is the recognition that racism is not just a personal attitude or belief but a system of power and oppression that is embedded in society. CRT argues that racism operates through social structures, institutions, and practices that produce and maintain racial inequality (Delgado and Stefancic, 2012). This insight has led CRT scholars to focus on how racism operates in law, education, healthcare, and other areas of social life.
Another important contribution of CRT is the recognition that race is not a fixed or natural category but a socially constructed concept that changes over time and across contexts. CRT scholars argue that race is a fluid and dynamic concept that is shaped by historical, social, and cultural factors (Omi and Winant, 2014). This assertion holds that race is a product of social thought and relations (Delgado and Stefancic 2017, p. 4). Race as a concept has no genetic or biological basis or foundation but is a social invention appropriated for the purpose of exclusion and dominance and even withdrawn when suitable. Indeed, people with common ethnic origins may differ in terms of their physical traits, like skin colour, height, hair texture, and other characteristics, but this forms a minuscule part of who we are as humans and has no correlation with personality, intelligence, or behaviour. CRT scholars have used this perspective to scrutinize the concept of a color-blind society, which presumes that race is no longer relevant in modern society.

CRT also emphasizes the importance of intersectionality, which refers to the interconnectedness of different forms of oppression, such as race, gender, class, and sexuality. CRT scholars argue that these forms of oppression are interlocking and mutually reinforcing and that they cannot be understood in isolation from each other (Crenshaw, 1991). This insight has led CRT scholars to focus on how multiple forms of oppression operate simultaneously in people's lives and how these experiences are shaped by social context.

Additionally, CRT has been influential in advocating for social justice and political activism. CRT scholars argue that racism is a pervasive and persistent problem in society and requires political action to address it (Crenshaw, 2011). Proponents of CRT assert that racism is ordinary, normalized, and part of the everyday experiences of most people of colour. Although the expressions might vary over time and space, its pervasiveness in society is undeniable. Because of
this ordinariness, racism is sometimes difficult to pinpoint and address as it is not acknowledged. This disregard is an attribute of white supremacy. White supremacy, or what Delgado and Stefancic (2017) note as “white-over-color ascendancy” offers both psychological and material advantages for the dominant group. In everyday encounters, privileges, both historical and material, accrue to white people because such advantages are deeply ingrained in the social structures and prejudices that shape society. The aforementioned perspective has motivated CRT scholars to participate in activism and advocacy efforts, as well as to strive towards influencing policies and promoting social transformation.

The final tenet is the notion of a “unique voice of color”. According to Delgado and Stefancic (2017), the voice of color thesis sits in tension with anti-essentialism. The voice of color thesis asserts that minority and oppressed writers and thinkers can better communicate issues of oppression than their white counterparts (Delgado and Stefancic, 2017). By extension, minority status brings with it a presumed competence to speak about race and racism because of lived experience. As a racialized man, my affinities were drawn to this project because it speaks to my experiences in Canada, to social justice, and to resistance against all forms of oppression, which is at the heart of my political commitments. Again, I believe that the oppressed would perpetually remain under the brunt of the oppressor until they mobilize and resist the force of oppression.

For this dissertation, critical race theory provides an important lens for critically assessing the locations of immigrant care workers in workplace hierarchies, their conditions of work, and how racism and racialization impacted the work they performed. I was particularly interested in how the process of racism and racialization in long-term care homes worked to “other” immigrant care workers in care homes. Critical race theory drew my attention to the normalization of systemic
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

racism in long-term care homes as an institution and how that validates prejudice and disparities in the everyday lives of people (Crenshaw, 2002; Delgado and Stefancic, 2012; Gillborn, 2015). In order to explore white dominance, it was pertinent to include critical whiteness theory to unpack whiteness in long-term care homes.

**Critical Whiteness Theory**

Beyond CRT, I draw on Critical Whiteness Theory to analyze how whiteness is normalized and invisible in society and to challenge the ways in which whiteness is maintained and reproduced through social and cultural practices. This dissertation aims to inform changes to the working conditions experienced by immigrant care workers in Canada, and make whiteness visible, both in terms of power and culture. For many white settlers, white dominance in long-term care physical environments, rules and regulations, habits, food, ways of interacting, and more are an unconsidered, normative, and invisible social order. My aim is to make this whiteness visible, including to those of white settler backgrounds in Canada, so that it can be critically interrogated and changed. Critical whiteness studies offer tools to do so, including the term “whiteness”, which is deployed to make visible white people and the privileges they enjoy at the expense of others (Levine-Rasky, 2013). White people, their privileges, values, and culture often pass as “un-raced” and neutral, as ‘race’ is used to describe non-white people (Dyer, 1997). Being critical of whiteness shifts attention to white hegemony, thereby discounting its neutrality (Dyer, 1997). White hegemony is instituted and supported by social structures that legitimate discrimination, exclusion, and oppression.

Whiteness as a social construct allows for the critical appraisal of structures and power relations that sustain dominance (Levine-Rasky, 2013, Puzan, 2003). An important attribute of critical
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Whiteness studies is how it draws attention to the operation of whiteness in everyday practice not necessarily as something situated in white bodies but to what Levine-Rasky (2013) refers to as a collective privilege. Dislodging racialization and racism from white bodies allows for a more holistic appraisal of their effects on racialized and white persons and/or groups (Dyer, 1997; Levine-Rasky, 2013). A more encompassing focus will account for the ineluctable relationality embedded in the study of race (Levine-Rasky, 2013). Notably, unequal power relations work to the advantage of dominant social groups at the expense of racialized others. In order to explore the unequal social and power relations that whiteness gets at, it is important to review some perspectives.

As a social relation, whiteness alerts us to material and symbolic relations as well as the contexts within which they are produced (Levine-Rasky, 2013). Through material and symbolic relations, we understand how social privilege works to the advantage of dominant groups. It is important to note that context always matters because not all white people may enjoy the social privileges that are referenced here. Gender, race, class, and other social categories intersect to position people on the continuum of privilege. However, on aggregate levels, colour matters, and the most underprivileged are Black women (Ahmed, 2002). Parsing out the attributes of whiteness provides insight into how it may operate in social relations. Whiteness allows for the interrogation of white privilege, European colonial violence, and oppression, and for the accentuation of non-white voices and the everyday practices that reifies racism.

Critical whiteness studies, like critical race theory, owes much to the work of W.E.B. Du Bois, who explains white privilege and its impact on the everyday lives of people. He problematizes the will of some members of society to “live in comfort” at the expense of others (Weinberg, 1970,
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Here he refers to white privilege without stating it in plain terms (Levine-Rasky, 2013). White privilege is systematically woven into the fabric of society to the extent that its consequences are almost invisible, normalized and accepted without contestation (Dyer, 1997). In examining whiteness, I deliberately place emphasis on the history of European colonial violence that adversely impacted other civilizations across the world (Ahmed, 2002; Levine-Rasky, 2013). Colonial dispossession and violent control of bodies, labor and land disrupted the livelihood of many nations across the world (Ahmed, 2002). Slavery and other violent appropriation of lives, labor and natural resources is a legacy of colonialism that continues to bear a brunt on the livelihood of many nations. The unequal power relations globally among nations and within nations - in the case of settler colonial states - are predicated on European colonialization (Coulthard, 2014). This phenomenon has impacted the international flow of labour in many ways, which have been well documented (Galabuzi, 2006; Yeates, 2009b; Lutz, 2011; Anderson and Shutes, 2014).

Drawing on Foucault’s notion of power as produced, Ahmed (2002) asserts that “colonialism also operated to produce the bodies of the colonized as already raced, by constituting them as objects of knowledge” (p. 48). In the quest of the colonizer to discursively construct an imagery of the colonized, the colonizer used the white masculine subject as a comparator to mark differences in other bodies (Ahmed, 2002). For Ahmed (2002), “this incitement to discourse operated precisely through the desire to know the truth about the bodies of others”, thus, constructing a discourse of other bodies (p. 49). Through scientific enterprise, the colonizer sought to legitimate the superiority of the white masculine race as empirical truth and ultimately marking the bodies of others as inferior. These narratives legitimated and sustained oppression of racialized bodies.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

To contest these parochial and unfounded knowledges generated across history, Black feminist writers have advanced the decolonization of knowledge. bell hooks notes that the vantage point of racialized people allows them to make use of their personal experiences of exclusion to challenge oppression (hooks, 1984). Critical whiteness scholars have thus sought to center this epistemic privilege of Black people to provide a counter-narrative and assert their lived experiences of oppression (Collins 2000, Yancy, 2008).

I chose these three theories because they allow for a holistic analysis of my research questions. Feminist political economy allows me to get at the everyday life experiences of immigrant care workers, the unequal social relations of gender, race, and class that shape these experiences, these worker’s insertion into the circuits of social reproduction, and the working of capitalism and colonialism involved. It allows me to identify who pays for long-term care with their lives and chances in ways that don’t show up in financial accounts and also who benefits. Together, critical race theory and critical whiteness studies allow a more complex analysis of race and white dominance in long-term care homes. Below, I proceed to detail key concepts that underpin the dissertation to clarify how they are utilized in the study and the meanings they evoke.

**Centered in Policy, Marginalized in Practice: Charting the Contours of Immigrant Care Work**

Immigrant care workers have long been pertinent contributors to the Canadian care economy, but the COVID-19 pandemic made their contributions more evident and tractable for all. Many immigrants, especially women, were at the forefront of the fight against COVID-19 and actively engaged in social reproductive labour when there was limited knowledge of the disease, its deadliness and contagiousness (Braedley and McWhinney, 2022). Paying the ultimate price with
their lives, some would die and many more would be infected (Turcotte and Savage, 2020; Gupta and Aitken, 2022). At the same time, there was public recognition of their efforts in the care economy and in long-term care homes especially (Turcotte and Savage, 2020). As many long-term care homes charted the course of their future and developed strategic plans, it was apparent that immigrant care workers were going to be drawn on more than ever before (Ramesar, 2021). The Canadian government in 2021, pivoted from its immigration focus on three main immigration streams under the Express Entry program - that is, Canadian Experience Class, Federal Skilled Work Program, Federal Skilled Trades Worker Program - to the Temporary Resident to Permanent Resident pathways, recognizing in part the contributions of immigrants within Canada (Government of Canada, 2021). The program offered six streams for essential workers and recent international graduates from Canadian institutions. Though the program was not specifically designed for long-term care workers, many care workers at the frontlines benefited from it.

These developments do not just happen, nor should they be taken for granted. They happened in the context of longstanding relations among countries and capitalist exploitation of immigrant care workers. Canada continues its historical legacy of welcoming immigrants into its economy, but the critical question is what happens after the welcome. What are the experiences of these new immigrants in the Canadian economy? How do racialialized immigrants navigate whiteness and systemic racism in Canada, especially in public institutions? In order to fully grasp and the historical, material and social relations that are central to immigrant care work, I operationalize several pertinent concepts utilized in the context of the dissertation. These concepts emerge from Feminist Political Economy, Critical Race Theory and Critical Whiteness Theory.
Immigrant Care Work

In this dissertation, and in the work of many scholars, including Pat Armstrong and Susan Braedley (2013), Mignon Duffy (2011), Evelyn Nakano Glenn (2010) and others, the term “care work” is used as an everyday term to describe social reproduction. As noted in the theoretical framework above, feminist political economists locate social reproduction at the center of human existence to argue that social reproduction is a kind of work that involves activities and relationships that contribute to and ensure the maintenance of people in everyday life as well as across generations (Braedley, 2006; Glenn, 2010; Luxton, 2006).

Care work ensures the maintenance of people in the context of familial relationships, in communities, and in public institutions. Although care work is central to human existence, it is undervalued because it is taken for granted in capitalist economies (Braedley and McWhinney, 2022). Glenn’s (2010) *Forced to Care: Coercion and Caregiving in America* presents three interlocking activities involved in care work. The first activity involves direct care for people’s physical and emotional needs as well as the provision of services to meet those needs (Glenn, 2010). The second activity is the maintenance of the immediate physical environment in which people live (Glenn, 2010). The third is what Glenn (2010) identifies as “the work of fostering people’s relationships and social connections, a form of caring labor that has been referred to as kin work or as community mothering” (p.5). These three foci of care work are evident in long-term care homes, with several authors emphasizing the need for meaningful relationships that improve the maintenance of the physical environment and direct care for physical and emotional needs. This work is multi-faceted and complex and as feminist writers have insisted, society must reject the ways in which care work is normalized as undervalued and often unpaid women’s work, or not work at all (Glenn, 2010; Duffy, 2011; Braedley and Luxton 2015).
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

However, my concern is not for all care work or all care workers. I am concerned with the paid care work performed by racialized immigrant workers, who are usually but not exclusively women. As I noted above, the workers are clustered at the bottom of professional hierarchies in the Canadian labour force (Block and Galabuzi, 2011; Block, 2017), and this is the case in long-term care workers, too (Syed, 2020). Despite significant labour shortages across the health care system and long-term care sector in Canada, and an increasing reliance on immigrant workers, they experience profoundly precarious working conditions that undermine their lives.

These working conditions make the conditions of care more difficult and more tenuous for everyone, including residents, their families, and other workers. Although care work in long-term care homes may involve all three aspects of care indicated above, the conditions of work in long-term care homes have meant that workers have largely stuck to the first two activities identified by Glenn (2010). With the rise of neoliberal new public management, the third aspect of care Glenn (2010) postulated is waning sharply in long-term care homes. In their analysis, Braedley et al. (2018) reveal that work organization in long-term care homes makes it difficult for workers to build and nurture relationships with residents - relationships that are important for the negotiation of intimate care.

Although these conceptualizations reveal important aspects of care, they fail to capture the transnational aspects of care that are crucial for racialized immigrant care workers. Arlie Hochschild coined the term, “global care chain”, to foreground the economic inequalities between Global North and South, which have contributed to the commodification of care work and the resultant uneven distribution of social reproductive labour (Hochschild, 2000; Lutz, 2011). Many racialized immigrant care workers leave behind their children, parents, family members, and
significant others in their home country to work in the care economies of the Global North. They are thus involved in transnational mothering, which comes with its own challenges (Anderson and Shutes, 2014). In the Canadian case, some immigrant care workers may move to Canada because of the prospect for reuniting with their family through family class applications for their children and partners or opportunities for applying for permanent residence with their family.

**Coercion**

Conceptualizing the conditions under which people care as coercive is pertinent to my analysis of racialized immigrant care work because racialized care workers' options for employment are often limited and restricted by host countries. Care work, whether paid and unpaid, is often imbued in some form of compulsion, which Glenn (2010) elucidates as coercion. Coercion hinges on gendered assumptions, values and beliefs about men and women and their roles in society and often works to the disadvantage of women (Glenn, 2010; Lutz, 2011; Misra and Merz, 2007). These gendered assumptions leave women burdened with multiple unpaid responsibilities in familial relationships as well as in paid labour.

Capitalist economies have exploited the gendered assumptions that frame women as natural carers, further marginalizing women and privatizing care into private households. These same exploitative gendered assumptions are used to frame immigrant care workers as natural care providers in long-term care homes. Glenn (2010) identified two types of coercion relevant to care work. The first is status obligation. Glenn (2010) explains that that “women are charged with a triple status duty to care, on the basis of (1) kinship (wife, daughter, mother), (2) gender (as women), and (3) sometimes race/class (as members of a subordinate group)” (p. 7). Unpaid care work tends to be embedded in gendered statuses like wife, mother, or daughter and are shaped by “market and kin
relations” (Glenn, 2010, p.7: Misra and Merz, 2007). It is through these mechanisms and social construction that labour predominantly done by women is unpaid, low paid, taken for-granted, and exploited. The long-term care sector struggles with low remuneration, high turnover rates, and poor conditions of work partly because of how care is undermined by capital accumulation. This has had deleterious effects on residents, care workers, families, and other staff, especially in for-profit homes where profit maximization gets in the way of quality care.

The second kind of coercion is racialized gendered servitude. Racialized gendered servitude is present when “one party has the power to command the services of another,” as demonstrated in the types of work undocumented immigrants and trafficked sex workers (those designated as “illegal”) engage in (Glenn, 2010, p.7). This form of care labor is historically steeped in the tortuous scourge of slavery, where people were dehumanized and owned by so-called slave masters. Apart from these two categories espoused by Glenn (2010), coercion as a concept can reveal the ways in which governments compel women through their policies and practices to take on unpaid care roles. In long-term care specifically, we can observe coercion in the policies that compel racialized immigrant care workers to work in the lowest-paid positions. Policies that support the unrecognition of immigrant credentials and arduous processes of credential validation work to compel immigrant care workers into low-paid jobs in host countries.

Feminist political economists like Banerjee et al. (2012) also conceptualize care as coercion when they explore structural violence in the context of long-term care homes. They argue that residents and care workers living and working in long-term care homes are subjected to structural violence that is embedded in the social and economic systems that shape the provision of care. Banerjee et al. (2012) discuss the institutionalization of care, which limits older adults’ and workers' autonomy
and control over their lives and work, respectively. Residents and workers in care homes may be subjected to strict schedules, routines, and rules that leave little room for their preferences. It is pertinent to note that economic and political systems shape institutional practices in long-term care homes. For instance, policies and practices that prioritize efficiency and cost-effectiveness over quality of care may contribute to neglect and mistreatment of residents and poor working conditions for care workers. Funding cuts and resource constraints tend to have direct correlation to the quality of care and work (Estabrooks et al., 2020).

Conditions of Work

Closely related to the concept of coercion are the conditions of work in long-term care homes. The incorporation of new public management in work organization and management in long-term care homes led to an emphasis on cost containment, quality improvement, efficiency and effectiveness, which adversely impacted the conditions of work in long-term care (Daly, 2015). For instance, in 2012, the province of Ontario tied its funding of long-term care homes to the consideration of Minimum Data Set (MDS), which is a clinical assessment tool for residents, without recourse to the potential ramifications for workers (Daly, 2015). Workers in long-term care now report being inundated with paperwork and a sense of detachment from residents, which impact care adversely (Lowndes and Struthers, 2016).

These conditions of work directly impact workers’ ability to provide care to residents (Lowndes and Struthers, 2016). Armstrong, Armstrong and Choiniere (2015) have asserted that the conditions of work are at the heart of debates about quality of care because such conditions are intertwined with conditions of care. Although this idea might almost pass as common sense, it has been rejected under neoliberal policy regimes that focus mainly on the commodification and
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

marketization of care (Baines and Cunningham, 2011a; Daly, 2015). A focus on the conditions of care that ensure workers’ labour with respect and dignity may translate into costs, which many states prefer to defer to the private market or families. Armstrong, Armstrong and Choiniere (2015) advocate for a stable work force, adequate staffing levels with an appropriate staff mix, an integrated system with care standards, appropriate training, and education as part of good working conditions. These good conditions create dignified and desirable care in long-term care homes and are beneficial for workers, residents, and other stakeholders.

Armstrong, Armstrong and Choiniere (2015) also show that health care aides in Canada “suffer more abuse than their counterparts in Nordic countries and that nurses are more likely than prison guards to be attacked at work” (p. vii). Workers in long-term care homes experience violence as a part of the everyday experience of caregiving (Daly et al., 2011). Many of these experiences of violence go unreported and are normalized in long-term care homes (Banerjee et al., 2015). Notably, the majority of those labouring under these poor working conditions in long-term care homes are women, many of whom are immigrants and racial minorities (Lowndes and Struthers, 2016; Syed, 2020).

These precarious working conditions have a far-reaching effect on racialized workers because they lack support within long-term care homes. Further, in small and rural communities where the numbers of racialized households are limited, these workers do not have opportunities for respite within the community. These conditions within and outside the workplace are exacerbated by white dominance, as explained below.
**Whiteness**

Whiteness as a concept emerges from the critical whiteness studies literature. According to Frankenberg “whiteness is the production and reproduction of dominance rather than subordination, normativity rather than marginality, and privilege rather than disadvantage” (p.236). With domination comes power; power to oppress, legitimize, and delegitimize, to sanction and approve, and normalize. Indeed, it is because of the dominance of whiteness that white privilege is often represented as “raceless” (Sullivan, 2006). In the context of this study, Frankenberg’s notion of whiteness is salient.

The dominance of whiteness permeates all aspects of long-term care homes and is produced and reproduced in social relations, often passing inconspicuously as white culture, and values are the norm. Policies, regulations, architecture, meals, activities, and all components of long-term care homes are steeped in white culture, and immigrant care workers are called to fit in these spaces with little or no experience. Racialized immigrant workers under these conditions are compelled to act “white” in order to identify with and feel part of the facility. According to Puzan (2003), acting white means adhering to the behaviors, values, beliefs, and practices of the dominant white culture. The challenge of approximating whiteness is far-reaching in rural and small-town Canadian long-term care homes, which may have a peculiar type of whiteness immersed in local culture and values.

The capitalist grip on long-term care policies and procedures, control over some services as well as progressive rise in for-profit ownership chains compounds the precarious locations and positions of immigrant care workers (Armstrong et al., 2020). The occurrence of such labour exploitation must not be taken for granted but be historicized.
Historically, colonization and racialization are the two major forces that define whiteness and white dominance (Nkomo and Al Ariss, 2014). Rooted in European imperialism were traces of ideological whiteness that viewed Europeans as civilized and non-whites as “wild savages” who needed to be civilized and purged from their savageness (Sullivan, 2006). This set the stage for dominance and white supremacy. Closely related to the previous ideological force was the work of Charles Darwin, which was appropriated in the industrialization process as a tool to validate differences among “races” and the dominance of the white race (Bonnett, 2002; Nkomo and Al Ariss, 2014; Hilario, Browne, and McFadden, 2018).

Industrialization created class distinctions between the owners of the means of production and those who sold their labour for wages; however, it was not until the white working class asserted themselves as white and privileged that racial divisions became evident (Roediger, 1999). In breaking down his “wages of whiteness” concept, W.E.B Du Bois (1903), explained that capitalists’ paid white, native-born workers higher wages than Black workers. Thus, creating a material benefit for white workers based on their whiteness. Nkomo and Al Ariss (2014) clarify that the discriminatory practices and derogatory characteristics assigned to Blacks were also assigned to immigrants from Europe as well, but they were eventually able to move into the “white” category. Thus, for Black workers their Blackness became a permanent marker of inferiority from which they could not distance themselves.

Roediger (1999) provides a deeper analysis with the claim that Black workers were used deliberately as a counterpoint to deflect the oppression the white working class experienced under the capitalist production in industrialization. According to Roediger (1999), whiteness became a means for formally indentured servants who became white workers in the factories to assert their
identity as freemen in contrast to enslaved Black workers. The construction of the white identity, which was contrasted with presumed Black inferiority, was pivotal in the exclusion of Black people from the privilege white people enjoyed (Nkomo and Al Ariss, 2014; Delgado and Stefancic, 2017). This in effect became a process of racialization of Black bodies, particularly to legitimate their oppression and the denial of privileges in the workplace. Consequently, one way of observing whiteness in organizations is to consider the processes and practices of exclusion and the material benefits that accrue to those who label others as inferior. From the foregoing, whiteness can be observed as both ideological and material, working to the benefit of those who hold such privilege.

Although historically, the mechanisms of whiteness and white privilege were overt as embedded in discriminatory laws and policies, more recently, covert mechanisms have been utilized in ways that are almost unnoticeable (Nkomo and Al Ariss, 2014; Huber and Solorzano, 2015). Within the covert space, whiteness allows white people to pass without having to acknowledge their race in organizations. As Frankenberg (1993) clearly points out, white people’s ability to do race without being conscious of it is a clear manifestation of whiteness. The peculiar ways in which white dominance impacts the lives of racialized immigrant workers, raises important questions about covert and overt racism which are unpacked below.

**Overt and Covert Racism**

Racism and racial discrimination impact the lives of many racialized immigrants and Canadians, yet they pass inconspicuously because of their insidious manifestations. Whether overt or covert, Canadians rarely “see” racism as they often juxtapose their situation with their American neighbours leaning on the mantra “it is better here”. Under the guise of the so-called Canadian
multiculturalism, racism has become more elusive yet pervasive with its clandestine machinations and mechanisms.

Overt racism refers to openly and explicitly expressed discriminatory attitudes or behaviours towards people based on their ethnicity, skin colour or any form of racial identity. It can be expressed in the form of racial slurs, hate speech, violence, or discrimination in areas such as education, employment, and the criminal justice system (Bonnilla-Silva, 2010). Historically, overt racism has been legislated in policies, programs, and laws against racialized people. The residential school system, the Sixties Scoop, the Chinese head tax, Japanese internment camps and discriminatory immigration policies against people of Asian, Caribbean, and African decent are a few examples of overt racism in Canada. Conversely, covert racism is more difficult to identify as it can be more subtly expressed.

Covert racism involves disguised acts of racism or discrimination that pass unnoticed or unremarked. Covert racism could also be normalized in policies, practices, and laws. Although they may have devastating implications for the oppressed, they are often not resisted and, in many ways, accepted. Whether operating on an individual or a more systemic level they take effort to expose. Racialized people feel and sense this effect but cannot always prove it. Concealed but palpable, racialized people know and experience it daily (Sue et al., 2007). Whether behind the smile, in an unwelcoming environment, or through excessive patronization, racialized people sense it. Sometimes it requires systematic investigation to reveal the insidious threads of covert racism, to avoid denial when the facts are laid bare.

In Canada, racism has been exacerbated by neoliberal restructuring, including the adoption of new public management ideologies (Daly, 2015) and the gradual shift towards precarious work
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

temporary, part-time, casual, low pay, contractual, no benefits, no job security, and poor working conditions (Galabuzi, 2006). Consequently, income, employment and other inequalities expanded over time, producing in its wake racialized class formation (Galabuzi, 2006). This class formation is particularly prominent in Canada’s urban areas, where the population of Canadians is diverse. Galabuzi’s (2006) analyses demonstrate the pertinence of statistical data in exposing subtle and often taken-for-granted forms of racism on aggregate levels.

This approach is of grave importance in Canada, where racism is dismissed and rejected in the consciousness of most of the populace. While I utilize a qualitative approach in this dissertation, I draw insights from Galabuzi’s (2006) quantitative analyses to flesh out how macro-level trends have implications for the everyday life of immigrant care workers in long-term care homes. Galabuzi’s (2006) use of the political economy approach to trace macro-level trends allowed me to trace the micro-level implications of systemic racism in one sector of the Canadian labour market. His analysis of the Canadian economy as colour-coded along racial lines is useful for unpacking immigrant work as precarious work concentrated at lower levels of occupational hierarchies.

Soltani (2017) asserts that Canada obstinately refuses its colonial legacy of racism by individualizing it rather than addressing its systemic and historical roots. Soltani (2017) interrogates the operation of covert racism under Liberal democracy, unmasking how it works to effectively erase racism from Canadian consciousness under the façade of multiculturalism. As she eloquently puts it, “under the guise of democracy, racism becomes much more difficult to locate and expose” (p. 18). Liberal democracy has long been heralded as the best means of governance with its values of freedom, justice, legal equality, and meritocracy. Although these
values do not pan out in the everyday experiences of the most vulnerable, the majority of the populace finds it difficult to reconcile racism with them. Thus, racism operates as an insidious, often un-recognized and ubiquitous reality in Canada.

Canada often pits its multiculturalism ideologies - cultural mosaic - against America’s melting pot narrative. Indeed, Canada’s racist history is different from that of the United States but jettisoning this history altogether is a blunder that continues to impact Canada at the individual, institutional, and systemic levels. Tapping into the Canadian psyche to understand why racial discrimination is unrecognized, Soltani (2017) discusses the possibilities for resisting and subverting systemic racism by challenging dominant policies via an introspective process of critical self-reflection and transformation.

Beyond ideological machinations, however, my work seeks to understand affectively the tacit expressions of racism to appreciate what it feels like to work as a racialized person in long-term care. Choudry and Smith (2016) further parse out how racism operates in the Canadian context, focusing on the multiple social relations that produce racism. They discuss the different categories of social relations that act together to produce racism and maintain that “discrimination and exploitation based on race, immigration status, class, and gender work in concert” (Choudry and Smith, 2016, p. 5). Women immigrant workers tend to engage in the most precarious forms of employment, characterized by low pay and poor working conditions. This is particularly true in the care economy, where live-in-caregivers and other migrant workers are not unionized. With less or no union protection, “they may be subject to abuse from employers and perhaps be more willing to accept this situation because of the relatively short duration of their employment abroad” (Choudry and Smith, 2016, p. 6).
Choudry and Smith tease out the connections between race and gender and class formations that result from precarious employment. They insist that neoliberal political ideologies shape immigration policies in ways that produce “exclusionary practices of racial othering” (Choudry and Smith, 2016, p.6). These practices tend to restrict and confine the freedoms and choices of migrant and immigrant labour from the Global South, and support restrictive and coercive labour processes, especially for temporary workers in Canada who work under precarious conditions with very limited protections. Immigrant women are at most risk of engaging in precarious work because of their gender, race, class, and immigration status. My analysis of covert racism is informed by these insights.

**Social Class**

Social class has long been a focus of academic inquiry among sociologists. Bourdieu (1984) defines it as a hierarchical ordering of individuals or groups within a society depending on their economic, cultural, and social resources. Class divisions are influenced by characteristics such as occupation, wealth, education, and social capital. These characteristics play a pertinent role in influencing people’s life chances, opportunities, and social mobility (Wright, 2005).

The Marxist perspective has had a fundamental impact on social class analysis, emphasizing the link between class and the means of production. Marx (1867) defined social class as individuals’ place within the capitalist mode of production, distinguishing between the bourgeoisie (owners of the means of production) and the proletariat (workers who sell their labour). This class division is defined by an inherent conflict of interests between the capitalist and working classes, emphasizing the exploitation and inequality inherent in capitalist systems (Marx, 1867).
Exploring the Experiences of Racialized Immigrant Care Workers

Contemporary social class studies have moved beyond Marxist frameworks to include intersectional perspectives. Wright’s (2005) concept of ‘contradictory class locations’ acknowledges that individuals might hold positions that cross many class categories. For example, an individual may have high levels of cultural capital but lack large economic resources, resulting in multiple class identities and experiences. This approach recognizes the fluidity and complexity of class dynamics in modern society (Wright, 2005). Furthermore, intersectional theories emphasize the interaction of socioeconomic class with other oppressive factors such as gender, race, and ethnicity (Crenshaw, 1989).

Social class is a multidimensional concept with economic, cultural, and social elements. It impacts people’s life chances, social mobility, and access to resources. While classical Marxist viewpoints have provided important insights into class dynamics, contemporary analyses combine multidimensional and intersectional techniques to reflect the intricacies of class identities and experiences. These methods emphasize the interaction of social class with other axes of oppression, such as gender and race, and acknowledge the role of cultural capital in reproducing class inequality (Crenshaw, 1989).

Concluding Thoughts

To delve deeper into the value attributed to care work, including the labor of immigrant care workers, and to shed light on the exploitative practices driven by capitalist and colonial systems that perpetuate the marginalization and disposability of racialized care workers, the dissertation draws upon feminist political economy, critical race studies, and critical whiteness studies. By combining these theoretical frameworks, the dissertation not only elucidates the social relations arising from capitalist exploitation but also recognizes the strength and agency of marginalized
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

individuals, specifically immigrant care workers. While each of these theories has its specific areas of focus, they are united in their commitment to uncovering power structures, challenging oppression, and advocating for social justice.

Following the expatiation theories that ground the research, concepts that are central to the dissertation are operationalized. The concepts delineated above show how racialized immigrant care workers are positioned in the Canadian care economy. The concepts are intentionally deployed to map out the contours of immigrant care work. With the limitations they face in the Canadian care economy, racialized immigrant care workers assert their agency in an uphill battle to serve residents in long-term care homes to the best of their abilities. To piece together the details of the struggle, it is important to review their conditions of work broadly.
Chapter 2: Critical to Care: The Conditions of Work for Racialized Immigrant Care Workers in Canada

Many OECD countries rely on migrant labour to meet the needs created by population ageing as the first cohorts of the baby boomer generation exit the workforce (Block and Dhinna, 2020; Chamberlain et al., 2019). Edo et al. (2020) note that immigrants in OECD countries increased from 7% in 1990 to over 12% in 2020. In the Canadian case, immigrant labour force represented 18.4% of the total Canadian labour force and 26.9% in 2020 (Statistics Canada, 2021a). Many OECD countries, including Canada, have created migration systems to attract international talent with specific skills required in their economies. Through this process, required skills are funneled to specific sectors of the economies of these countries. The linkage of skills and education to immigration streams and programs has been pursued in many high-income countries in Europe, North America and Nordic countries (Boubtane, Dumont, and Rault, 2016). Canada is often used as a model for other countries as it continues to streamline and refine its immigration policies to meet its economic priorities and needs. Canada utilizes several immigration streams to attract immigrants into its economy, notably its care economy, which is the subject of this dissertation. and more specifically, its care economy for which this dissertation is concerned.

While immigration pathways have attracted scores of immigrants into Canada’s care economy and long-term care homes in particular (Atanackovic and Bourgeault, 2013; Lowndes and Struthers, 2016; Braedley et al., 2018), little is known about the experiences of immigrant care workers in long-term care homes (Syed, 2020), especially in rural and small towns. This lacuna in extant research calls for an exploration of these experiences, especially in the context of growing demands for racialized immigrant care workers in Canada. Recognizing this gap, this research aims to
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

foreground the experiences of racialized care workers and give voice to their social relations and encounters in long-term care homes, which are designed for white-settler Canadians. What are the motivations and social locations of immigrant care workers in Canada, and how does white dominance impact their everyday experiences of working in long-term care homes? In this chapter, I review academic and grey literature pertaining to the long-term care home labour force, labour process, and working conditions, and on whiteness in public institutions.

**Racialized Immigrant Care Workers: Creating a Long-term care Labour Force**

Maintaining the health care labour force has become an increasing challenge in Canada, including in the long-term care home sector, and immigration has been touted as a key answer. At the same time, governments’ share of health care costs is a continual political concern exacerbated by socio-demographic aging and fears about escalating health and long-term care demands by an older population (Estabrooks et al., 2020; Armstrong et al., 2020). Further, long-term care homes require a 24-hour/7 day-a-week labour force, so the labour must be flexible. In the absence of alternatives, racialized immigrant care workers are a flexible, more easily exploited labour force than Canadian-born and white workers. Below, I review the academic literature on long-term care homes and the increasing reliance on immigrant labour.

Increasingly, Canada relies on racialized immigrant care labour to meet the acute shortages of care workers in home care and in long-term care homes (Chamberlain et al., 2019; Sayin et al., 2021). Most racialized immigrant care workers involved in the Canadian care economy are women, despite the growing number of male immigrant care workers (Booi et al., 2021; Estabrooks et al., 2020; Storm, Braedley, and Chivers, 2017). These workers are located at the lower levels of workplace hierarchy, employed precariously with limited options for occupational mobility.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

(Banerjee et al., 2015; CHC, 2018; Lightman, 2019; Syed, 2020). Immigrant care workers continue to take on gendered impacts of care labour in Canada as care is undervalued, underpaid, and considered women’s work (Lightman, 2019; Lowndes and Struthers, 2016). An economic disadvantage accrues to immigrant care workers because care work is associated with women’s work (Lightman, 2019). The historical trajectory of immigrant care workers’ involvement in Canada’s care economy reveals policies and programs designed to recruit immigrants to fill in the care gap.

Canada began recruiting immigrant women into its care economy in the 1950s through the Caribbean Domestic Scheme (CDS) (Tungohan, 2013). Shortly after this time period, feminist efforts in the second wave of feminism yielded significant gains as middle-class women pursued careers outside their homes. As a result, a care gap was created as women who were traditionally responsible for care in the home worked in paid employment outside the home. This led to an increase in the need for new accessible public childcare arrangements (Tungohan, 2013).

Though the CDS was designed for private care arrangements in individual households, it met some aspects of the care gap created. In 1981, the Foreign Domestic Movements (FDM) replaced the CDS (Tungohan, 2013). The FDM provided some labour protection and streamlined the path to permanent residency for domestic care workers. With FDM, domestic care workers could gain permanent residency after working as living-in-caregivers for 24 months and an additional 12 months as live-out carers and meeting other requirements. Eventually, in 1992, the FDM was replaced with the Live-in Caregiver program. This program favoured immigrants with educational credentials and work experience and operated as a gateway for nurses from countries that trained nurses for migration, especially the Philippines (Tungohan, 2013). Implicit in the requirements of
this new program was the deskilling of racialized women in the Canadian care economy (Salami and Nelson, 2014). Degree-holding nurses working as live-in-caregivers were unable to practice in their professional field without further Canadian education, as their foreign credentials were not recognized in Canada. This was not only about deskilling but political choice by neoliberal Canada to acquire the most experienced labour force at the lowest cost. Many immigrant women are thus precariously positioned both in their home country as well as in the host country. Tungohan’s (2013) study on home care work found that live-in-caregivers experienced an “ideological impasse”, where on the one hand, they were expected to rescue their home countries via remittances that make up a core part of gross domestic product and, on the other hand, they were vilified for not being physically present to meet their maternal obligations (Tungohan, 2013; Rodriguez, 2014). These tensions have also been noted by Hochschild (2000); Hondagneu-Sotelo and Avila (2006); Parrenas (2005); Lutz (2011); Anderson and Shutes (2014). These paradoxes and conditions also affect long-term care home workers, as neoliberal Canadian governments’ retrenchment politics and cost containment challenges the sector’s quality of care (Lowndes and Struthers, 2016).

Unlike home care, racialized immigrants enter long-term care home work through diverse immigration and educational pathways: as international students in Canadian vocational nursing programs, as temporary foreign workers, as family-class immigrants, and as refugees (Nourpanah, 2019 a, b). In recent years, vocational nursing programs have been used by foreign nurses as a transit point to permanent residency as noted by Nourpanah (2019b). For example, immigrants from South India are channeled through designated organizations in their home country that support them in applying for vocational graduate programs in Canada (Nourpanah, 2019b). After graduating from these programs, these students, who are often registered nurses in their home
country, obtain work permits and pursue permanent residency before their work permits expire. Throughout the duration of their studies and work permits, students participate in the Canadian labour force. Immigrant care workers who utilize this pathway may be willing to endure poor working conditions to achieve their ultimate goal of becoming permanent residents. Conversely, Canadian governments offload the costs of recruiting immigrant labour by making these vocational programs accessible (Nourpanah, 2019b).

In Canada, like in many wealthy countries, immigrant labour has become a key defining feature of the care sector (Lightman, 2019). Migrants who move from poorer to richer countries for employment tend to find themselves in secondary sectors of the labor market, which offer precarious work with limited protections, benefits, autonomy, or control (Kalleberg, 2011; Lightman, 2019). Paid care work is increasingly being viewed as part of a global care chain, where poor immigrant women, often racialized, provide care for pay in wealthier countries (Hochschild, 2012). As high-income countries experience rapidly aging populations and low birth rates, migrant workers are seen as a solution to mounting care deficits (Lightman, 2019). Again, as Canadian women are increasingly entering or re-entering the workforce, immigrant care workers have been drawn on to fill the gap. Lightman (2019) notes that many of these workers arrive with temporary work permits designed to discourage broader integration or settlement and may face widespread workplace discrimination and abuse, all while negotiating intergenerational family separations.

In Canadian long-term care homes, racialized immigrant care workers are overrepresented among health care aides or personal support workers (Bourgeault et al., 2010; Estabrooks et al., 2020; Lightman, 2021; Syed et al., 2016). At that occupational level, gender, race, and class intersect in
ways that impact their everyday experiences as racialized immigrant women or men doing low
waged essential care jobs (Lightman, 2021).

**Working Conditions in Canadian Long-term Care Homes**

The conditions of work are, in many ways, structured by the needs of the residents who receive care in these settings. Due to decreasing bed supply relative to demand, and higher expectations that people will be cared for at home, Canadians are entering long-term care homes sicker and in later stages of their life than ever before (Armstrong et al., 2020; Banerjee et al., 2015). According to Canadian Institute for Health Information (CIHI 2014), 60% of residents in long-term care homes have dementia, and of the 95% of residents who need assistance with activities of daily living, 80% need extensive assistance. These high levels of resident acuity require more assistance from workers, including nursing staff who dress, bathe, toilet, and feed residents, laundry and housekeeping staff who have more workload as a result of both more mess and higher risks of infection. Also, food service workers must prepare more textures and more kinds of food to meet the needs of differently ill and frail individuals. Given that staffing levels have not increased to meet these new demands further strain and pressure on already struggling workers (Armstrong and Day, 2017).

As noted in Chapter 3, the organization of care work is shaped by policies and regulatory frameworks at the federal and provincial/territorial levels. These policies and frameworks establish standards for staffing levels, training, and working conditions for care workers, as well as guidelines for the delivery of care services (Armstrong et al., 2020). The organization of work may also be influenced by staffing and training requirements and recommendations proposed by
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

agencies like the Canadian standards association, the College of Licensed Practical Nurses of British Columbia, and the Canadian Nurses’ Association.

Care models and practices may also shape how work is organized in long-term care homes. Many models for care have been implemented in long-term care homes in Canada, including the traditional medical model and various iterations of person-centered care and relationship-centered care (Chamberlain et al., 2019). Each of these models has different implications for the organization of care work, with the traditional medical model typically involving a more hierarchical approach to care delivery and the person-centered and relationship-centered models emphasizing a more collaborative and holistic approach. With the hierarchical approach to care delivery, there is strict adherence to work protocols, with frontline workers experiencing a lack of autonomy over the work they do (Banerjee et al., 2015).

Work organization in long-term care homes is also influenced by funding models. Long-term care homes in Canada are predominantly publicly funded, with the federal government providing funding through transfer payments to the provinces and territories, which in turn fund the delivery of long-term care services through different combinations of public, non-profit, for-profit providers (Armstrong et al., 2020). These providers have implications for the organization of care work, with private for-profit homes potentially prioritizing profit over quality of care and non-profit homes potentially having more flexibility to prioritize resident needs (Armstrong et al., 2020). When profit is prioritized over the quality of care, care homes offer the bare minimum standards of care, including cutting down on direct care hours which increases the workload and pressure on care workers. While these factors go some way to shape some differences across
individual nursing homes and provincial jurisdictions, many conditions of work are similar in long-term care homes across Canada.

**Shift Work**

Long-term care home work is shift work (Cloutier et al., 2016). Shift work refers to a work schedule in which different groups of workers rotate through a 24-hour period to ensure that there is staff available to provide care always (Caruso, 2014). In long-term care, this typically involves three eight-hour shifts: day shift, evening shift, and night shift, although some workers may do twelve-hours, and split shifts and shorter shifts at key times of day are also common. Shift work in long-term care is influenced by a range of factors, including staffing levels, workload demands, and the preferences of care providers (CHC, 2018).

One of the key challenges associated with shift work in long-term care is the impact on care workers’ health and well-being (Ganesan et al., 2019; Dall’Ora et al., 2020). Shift work has been linked to a range of negative health outcomes, including fatigue, sleep disturbances, and increased risk of chronic diseases such as cardiovascular disease and diabetes (Ganesan et al., 2019). In addition, shift work can lead to social and family disruption, as care workers may have to work during evenings and weekends when their families and friends are available for social activities (Dall’Ora et al., 2020). To address these challenges and others described below, there have been calls for increased staffing levels in long-term care to reduce the workload demands on care and minimize the need for overtime and extended shifts (Canadian Federation of Nurses Unions, 2021).

**Staffing Levels, Skill Mix, and Divisions of Labour**

The staffing level refers to the ratio of workers assigned to residents; the skill mix refers to the varieties of professions and occupations involved in the provision of care; and the division of
labour refers to which workers do specific tasks and how work is shared. All are important in determining the conditions of work. The numbers and professional/occupational mix of workers typically on a shift in long-term care homes can vary according to the size of the facility, the number of residents, and the staffing requirements set out by regulatory bodies.

A study by the Canadian Institute for Health Information (CIHI) found that, on average, there was 3.1 direct care staff per resident on day shifts and 2.8 direct care staff per resident on evening shifts in Canadian long-term care homes in 2018-2019 (CIHI, 2020), but there is no data for other kinds of workers. However, staffing levels can vary significantly between different long-term care homes and regions in Canada. In a survey of nurses working in long-term care in Manitoba, 56% mentioned that staffing levels at their workplaces were inadequate (CHC, 2018). As cost containment strategies, managerial practices, and privatization are increasing in long-term care home delivery, staffing levels and mix have been gravely impacted (Lowndes and Struthers, 2016). Many long-term care homes have tried to resolve the inadequate staffing levels with ad hoc strategies like hiring temporary, casual, and contract staff (CHC, 2018). These strategies tend to adversely impact the continuity needed for workers to develop care relationships that foster dignity and respect and improve the care experience (Armstrong et al., 2020).

Skill mix and divisions of labour are other facets of long-term care work. The division of labour refers to the distribution of tasks and responsibilities among different types of care providers in long-term care homes. Divisions of labour in long-term care are shaped in part by role expectations and scope of practice (Syed et al., 2016). Considering skill mix, registered nurses, for example, are typically expected to provide more complex and specialized care, while care aides are expected to provide personal care and assistance with activities of daily living. However, there can be
variation in these expectations and scopes of practice depending on the care model, needs of residents, and funding model. Traditional care models that emanate from the medical model tend to have a rigid division of labour compared to relationship-centered models. For-profit homes may also use a more hierarchical division of labour to maximize so-called “efficiency” at the expense of care, while non-profit homes may prioritize resident needs and may use a more collaborative and flexible division of labour to meet those needs (Syed et al., 2016). These divisions of labour are gendered, raced, and classed.

**Structural Violence, Racism, Sexism and Xenophobia on the Job**

Appropriate staffing levels ensure that there are enough workers on the floor to respond to resident needs and to develop the relationships needed to provide care with dignity and respect. Poor staffing levels, heavy workload, and poor work organization negatively affect resident satisfaction and increase violence experienced by residents and workers (Armstrong, Armstrong and Choiniere, 2015). Armstrong, Armstrong and Choiniere (2015) note that health care aides in Canada experience more violence on the job than their counterparts in Nordic countries. In their research survey, they found that Canadian personal support workers reported six times more workplace violence compared to their Nordic counterparts (Armstrong, Armstrong and Choiniere, 2015). In many long-term care homes, violence is normalized as part of everyday work life (Banerjee et al., 2008; Syed, 2020). Often, care workers are blamed for inciting violent acts from residents. Their approach to care is perceived as the problem, while structural issues are largely ignored.

Violence against workers is likely to increase when other conditions of work deteriorate and vice versa (Armstrong, Armstrong and Choiniere, 2015). Good conditions of care allow care workers
to do their jobs with dignity and contribute to the quality of health and overall well-being of residents. With good conditions of work, it is easier to recruit and retain competent staff as there is high satisfaction among workers (Armstrong, Armstrong and Choiniere, 2015). Conversely, poor conditions of work increase employee turnover, absenteeism, worker burnout and fatigue and adversely impact worker psychological health and safety (Armstrong, Armstrong and Choiniere, 2015; Braedley et al., 2018; Estabrooks et al., 2020). These conditions may be exacerbated for immigrant care workers who tend to be concentrated in low waged employment, with minimal benefits and fewer opportunities for employment mobility (Syed, 2020).

Much of the exploitation of racialized, feminized labour in long-term care homes happens in for-profit homes where the desire for profit maximization overrides the provision of quality care under dignified conditions (Syed, 2020). Compared to not-for-profit facilities and public facilities, private facilities have less desirable conditions of work and overall less quality (Armstrong et al., 2011; Banerjee et al., 2015). Apart from adequate staffing levels, care workers need continued education and training to improve their skills, adequate time to care hours, autonomy over their work, the right tools, instruments and supplies in adequate numbers, and decent remuneration (Armstrong et al., 2020; Lowndes and Struthers, 2016).

Many racialized immigrant women are drawn into multiple precarious jobs because they struggle to find jobs as their credentials are not recognized (Valtonen, 2008; Syed, 2020). Racialized care workers bear the brunt of the compounding effects of precarity as they navigate multiple temporary positions in long-term care just to get by (Armstrong et al., 2020). They tend to occupy the lowest and most precarious waged labour because of the limited opportunities they have and the complex credential validation systems they are required to navigate to be deemed legitimate (Syed, 2020).
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

This trend leads to an observable hierarchal ordering of care workers as racialized care workers are concentrated at the lowest waged positions in long-term care homes (Duffy, 2011; CHC, 2018; Syed, 2020). Additionally, racialized immigrant care workers navigate overt, covert racism, sexism, and xenophobia in long-term care homes across Canada (Braedley et al., 2018). These experiences are often glossed over, covered, and misunderstood as cultural differences (Braedley et al., 2018).

This is where gender, race and class intersect profoundly, as low waged racialized immigrant women share similar life and family experiences because of their low waged employment. Their low income and less power have implications for their social status on and off the job. Within the health care system as a whole, long-term care home workers are underpaid compared to their colleagues in acute care settings, which results in low motivation and high turnover rates (Lowndes and Struthers, 2016). A broader appraisal of the structural processes at play reveals how colonialism and dominance operate to keep racialized immigrant care workers in the most subservient positions without clear pathways to break out of those glass ceilings. Though the extant literature reviewed above details the precarious conditions under which long-term care home workers labour and how capitalism operates to keep immigrant care workers in lower positions, it does little to address the everyday experiences of immigrant care workers in long-term care homes.

I explore whiteness in public institutions like long-term care homes to get at this salient point.

Whiteness and Racialization in Institutional Settings

Exploring whiteness in public institutions reveals the multiple operations of race and racialization in organizations. Whether overt or covert, racialized workers feel the discomfort and emotional harm racism brings to institutional settings, ironically, as they labour to care for others even in the
most precarious situations. Whiteness as an approach to understanding racism allows for the piecing together of social relations that emanate from care work and the emotional burden exerted on care workers. Although whiteness and white privilege may refer to phenotypical differences, it is mainly about dominance (Delgado and Stefancic, 2017).

Whiteness is in operation in organizations and institutions in many ways. For example, it is in operation when the progression of white employees to the top positions of organizations is perceived as natural, and the progression of racialized people to similar positions is perceived as a privilege or a form of invasion of white space (Nkomo and Al Ariss, 2014). Similarly, the normalization of immigrant care workers at the bottom of occupational hierarchies is also an operation of whiteness. Whiteness is a resource that accrues to white people, including well-meaning white people, and they can reject and/or reclaim it at any time (Delgado and Stefancic, 2017). This translates into real power. In Canada, immigrant care workers are disproportionately represented in direct care work. Estabrooks et al. (2020) assert that 60% of direct care workers in Alberta providing hands-on care speak English as a second language, and about half of those in urban areas are immigrants. Direct care workers, called personal support workers or care aides in most Canadian jurisdictions, are the most precarious workers in long-term care homes when working conditions are considered (Sloane et al., 2021). Another crucial aspect of whiteness is its elusiveness in plain sight. I turn to some studies to explore the elusiveness of whiteness in everyday practices below.

Mapedzahama, Rudge, West, and Perron’s (2012) study on Black immigrant nurses in Australian nursing workplaces fleshes out the experience of everyday racism in institutional spaces. Drawing from Filomena Essed’s (1991) theorization of everyday racism, they discuss covert and mundane
forms of racism in Australian nursing workplaces. According to Mapedzahama et al. (2012), Black immigrant nurses became aware of their Black embodiment when they began to observe the construction of their otherness in the Australian workplace. Predetermined racial scripts were written onto their bodies and they were expected to follow suit. Black immigrant workers felt they were scripted and read as incompetent and lacking required practice skills because of their Blackness (Mapedzahama et al., 2012). Similarly, Rudo, a participant in Sethi’s (2016) photovoice study in Canada, reveals in her explanation of the relationship between her Black embodiment and a washing machine picture she took that, “the washing machine is full of dirty things inside. People look at us as if we are dirty…” (p. 23)

This is what defines the process of racialization as noted in the work of Ahmed (2002). For Ahmed (2002), through the process of racialization, which is historically layered, and complex, racialized bodies are produced as having peculiar characteristics. The “racial body” is produced through knowledge and by how it is constituted in social and bodily space in the everyday encounters with the other (Ahmed, 2002).

Another crucial yet challenging attribute of racism its unnoticeable character. Everyday racism is pervasive because it is embedded in mundane, taken-for-granted practices that make it difficult to pinpoint and include “patterns of avoidance and feelings of non-acceptance that are difficult to place” (Mapedzahama et al., 2012, p.159). In their study, Mapedzahama et al. (2012) found that managers neglected to do anything substantive against racism under the misguided idea that if you do not do anything about it, you cannot be accused of discrimination. They would rather re-assign a racist patient to a white nurse rather than address the issue. Essed (2002) espoused that racism
is not just about commission but also omission, not just doing but also not doing. Thus, the passivity or outright denial of the existence or dissociation from racism is tantamount to racism.

Again, Mapedzahama et al. (2012) discuss the telling experience of a Black immigrant nurse, Tete in their study. Tete reveals experiencing heart palpitations and tremors when she walks at the workplace. According to Mapedzahama et al. (2012), being subjected to hyper-surveillance under a white gaze in nursing institutions gives rise to self-doubt and psychological challenges as migrant nurses strive to cope. When racialized care workers are consistently watched and monitored, it may lead to self-doubt and reduce their confidence, especially for those who are new to the job (Mapedzahama et al., 2012). The tension that comes with knowing that you are being watched could lead to mistakes, consequently perpetuating the false narrative of incompetence often associated with racialized care workers (Mapedzahama et al., 2012). This is corroborated by the work of Braedley et al. (2018) which reveals that racialized workers' experience of racism and racialization in long-term care homes create an emotional burden with psychological health and safety implications. Having to consistently work to prove your worth in a tense work environment with low staffing levels adds another layer of burden to immigrant care workers. Traversing subtle racist encounters on a daily basis could have debilitating ramifications for racialized workers.

In a study of racialized nurses in the white institutional space of the American healthcare system, Cottingham, Johnson, and Erickson (2018) report that women of color experience an emotional double shift as they negotiate social relations on the job. They experienced excessive job-related stress, performed disproportionate amounts of emotional labor and experienced depleted emotional resources which in turn adversely impacted patient care. Women of color are required
to perform an emotional “double shift” in order to be successful in “white institutions” (Evans, 2013; Cottingham, Johnson, and Erickson, 2018).

Utilizing a photovoice method in a project titled “Using the Eye of the Camera to Bare Racism” Sethi (2016) profoundly captures the experiences of immigrant care workers in long-term care homes. She reveals that immigrant personal support workers experienced subtle everyday racism in the form of stares, a feeling of oddness, apathy from employers and a lack of support. These experiences are well articulated in the explanation of Rudo, a participant in the study who explained a photo of a brick wall she took;

Sometimes when I am working, I feel I hit a brick wall. There is no one to explain how I feel with the racist behaviour of residents and some co-workers. When I complain to managers, they won’t listen. The staff don’t understand my culture. So, I feel like giving up. I cannot see beyond the brick wall. I cry and I get really depressed. I feel fatigued. I think this is too much for my body and my mind. (p. 24)

Rudo explains how overwhelmed she was feeling at the workplace due to everyday racist encounters she experienced. Worse, she explains, is how she feels unsupported by employers at the workplace. The denial of racism and the lack of support create a work environment that is emotionally draining and unwelcoming. This is an example of what Sandler (2005) considers a “chilly climate” at the workplace.

When the experiences of immigrant care workers are assessed without reference to their experience and perspectives, there is the tendency to perceive them as timid powerless workers enduring the scourge of white imperial dominance. Contrary to this perception, racialized immigrant workers perceive themselves as resilient workers who can navigate the most challenging conditions of work to provide a decent living for themselves and their families. England and Dyck (2012) advocate for a more complex understanding of racism and exploitation which appreciates the agency,
resilience, and resistance of racialized care workers, rather than one that merely focuses on discrimination.

**Concluding Thoughts**

Long-term care workers in Nova Scotia, Ontario, and British Columbia continue to face various challenges, including staffing shortages, low wages, and poor working conditions. These issues have been exacerbated by the COVID-19 pandemic, which has highlighted the need for significant improvements in the long-term care sector (Armstrong et al., 2020; Estabrooks et al., 2020).

This chapter reviewed literature on the conditions of work experienced by racialized immigrant care workers in the Canadian context. The reviewed literature highlights the significant contributions made by immigrant care workers to the care economy in Canada, while also underscoring the exploitative treatment they often face. This exploitation is particularly evident in light of concerns surrounding the aging population and rising healthcare costs. The existing working conditions in long-term care homes, which are shaped by limited healthcare resources, further exacerbate the challenges faced by racialized immigrant workers. Additionally, the presence of racism adds an additional layer of pressure, as these workers are subjected to everyday microaggressions that intensify the emotional strain associated with their care work.

The significant findings highlighted in the literature emphasize the necessity for research that specifically investigates the experiences of historically marginalized and excluded groups within healthcare settings, particularly in the context of long-term care homes. Such research must aim at understanding how working conditions affect the most vulnerable workers.

Additionally, there is a notable gap in the existing literature concerning the experiences of immigrant care workers in rural areas and small towns. Therefore, it is crucial to thoroughly
document and examine the unique challenges and circumstances faced by these immigrant care workers in these specific settings. By addressing these gaps, a more comprehensive understanding of the working conditions and experiences of historically oppressed and excluded groups in healthcare can be achieved.
Chapter 3: The Policy Context for Immigrant Long-term Care Work in Canada: Nova Scotia, Ontario, and British Columbia

While the literature on long-term care home working conditions for racialized and immigrant workers shows patterns across white-settler jurisdictions, as shown in Chapter Two, there are also differences across contexts. The extent to which these differences affect the conditions and experiences of long-term care work for these workers is not entirely clear. However, the policy directions across context are important to note. In this chapter, I describe the contexts in which this research project was conducted.

I take up my research questions in three Canadian provinces, Nova Scotia, Ontario, and British Columbia, to explore how racialized, immigrant long-term care workers’ conditions of work are affected by the policies shaping their jobs and livelihoods, and what unions have to say about them. There are two relevant policy realms at play. First, there are policies and regulations that structure long-term care homes with implications for conditions of work. The second is the immigration policies that control who can enter, for how long, with what family, with what credential recognition and citizenship status. I take up these pertinent issues in the context of policies and union activism across these provinces. Union perspectives are included in this chapter because they highlight critical issues in this heavily unionized sector. Unions are also racialized and gendered organizations that do not always represent all their workers equally. Across union activity, the significant core issues affecting long-term care workers often crowd out direct action on issues of race, gender, immigration, and equity, although some unions are attentive to these issues across their membership (Lowndes and Struthers, 2016).
In the Canadian context, long-term care home services are designated as a provincial responsibility, and while not included under the Canada Health Act, have developed as a universally available public service under provincial control. As a result, there are variations in service delivery policies in long-term care homes across Canada (Armstrong and Braedley, 2013). The federal government establishes some standards for health services on which the federal share of funding health programs is based, but provinces have autonomy over programs, and develop services for their jurisdictions (Armstrong, 2017; Deber, 2014).

Provinces are responsible for licensing long-term care homes in their jurisdiction. Although they may vary considerably, provincial standards are enforceable and monitored in accordance with regulations. Each of the three provinces included in this project has its own legislation, regulations and policies that set standards for services provided. Compliance with these regulations and policies may have implications for funding (Daly, 2015). To receive government funding, long-term care homes must meet certain regulatory requirements which vary by province. Compliance also ensures the facility's license to operate. Generally, long-term care policies are designed to address access, delivery, quality of care, and efficiency (Daly, 2015).

In what follows, I provide an overview of the long-term care home policy frameworks and immigration policies pertinent for each of the jurisdictions involved in this research, as well as related long-term care worker union activities and positions. I move from East to West in doing so, beginning with Nova Scotia, then describing Ontario, and finally British Columbia. I focus on policies and activities pertinent to this study but acknowledge that the sheer scope and scale of long-term care home policy, which is one of the most regulated public services sectors and one subject to innumerable inquiries, investigations, reports and more, makes comprehensive policy
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

review beyond the scope of this research. While there are significant differences among the policies and governance affecting long-term care homes across these jurisdictions, the conditions of work that result are more similar than different, as I will show in this and the following chapter.

Immigration policies and programs are the channels through which immigrants get into each province and transition into work in long-term care homes. Immigration policies have some differences too, but once again, the similarities for care workers across these three provinces are striking.

Apart from the provincial nominee programs outlined below, there are federal programs that can offer pathways to permanent residence for immigrant care workers in Canada. There is the Express Entry points system, family sponsorship, Atlantic Immigration Program, Caregivers Stream, Start-up Visa, Self-employed, Rural and Northern Immigration Pilot, Agri-Food Pilot, and the Temporary resident to Permanent Resident Pathway (now expired), Permanent Residence Pathways for Hong Kong residents, Economic Mobility Pathways Pilot, and Refugees Pathway (Immigration, Refugees and Citizenship Canada, 2022). Though these federal programs do not offer direct pathways to permanent residence for immigrant care workers in long-term care homes, immigrant care workers are able to use federal programs to enter Canada after working for a year.

The Nova Scotia Context

Nova Scotia is located on the eastern coast of the country. At the time of the study in 2018, the population of Nova Scotia was approximately 965,382 persons, with about 18.6% aged 65 years and older (Statistics Canada 2018a). Nova Scotia has one of the highest proportions of seniors (65+) in the country; in 2015, seniors accounted for 18.9% of the population (Statistics Canada, 2015). This has implications for the demand for long-term care homes. At the time of this research,
the province was led by Premier Stephen McNeil of the Liberal Party. He led the party from 2013 until February 2021, when he announced his resignation (Government of Nova Scotia, 2018b).

Also, at the time of the research, the government of Nova Scotia had a number of priorities, including improving healthcare, investing in infrastructure, and promoting economic growth (Government of Nova Scotia, 2018c). The province has a diversified economy with industries such as fishing, forestry, and agriculture, as well as a growing technology sector.

**Overview**

There are approximately 33 long-term care beds per 1,000 seniors aged 65 years or older in Nova Scotia (CIHI, 2021a). Long-term care homes in Nova Scotia are owned and operated by a combination of for-profit, non-profit, and government entities. Out of the 84 long-term care homes in Nova Scotia, 44% were owned by for-profit organizations, 42% were owned by, not-for-profit organizations and 14% were publicly owned (CIHI, 2021b).

The labour force in long-term care homes in Nova Scotia is composed of a variety of occupations and professions including registered nurses, licensed practical nurses, care aides, and support staff, including housekeepers, maintenance, laundry, and food workers. During the pandemic, the province implemented policies to address some long-term care labour force shortage issues. The province introduced policies to improve working conditions and wages for care aides, including a new wage grid and a program to train and certify more workers in the field (Government of Nova Scotia, 2021).

**The Long-term care Policy Context in Nova Scotia**

There are two types of government-funded care homes in Nova Scotia: Residential Care Facilities (RCF) and Nursing Homes (Department of Health and Wellness, 2011). This project focuses on
Nursing Homes. Individuals who access RCFs do not require 24-hour nursing care, while those who live in nursing homes do. The Homes for Special Care Act (1989) and the Social Assistance Act (1989) are the main legislations governing long-term care homes in Nova Scotia. These Acts have been the subject of many union debates in recent years, as unions contest their ability to address emerging, complex challenges in long-term care homes.

In Nova Scotia, Continuing Care Coordinators are responsible for assessing the needs of seniors and recommending a government funded LTC (long-term care home) for them (Department of Health and Wellness, 2016). Continuing Care Services are administered and delivered by the Nova Scotia Health Authority and funded by the Department of Health and Wellness. Long Term Care is part of the service and funding agreements under the purview of the Nova Scotia Health Authority. In 2015, Nova Scotia merged nine district health authorities into one provincial health authority consisting of four geographic zones.

In Nova Scotia, the Department of Health and Wellness (DHW) plays an instrumental role in setting out regulations that guide eligibility for long-term care homes. For instance, if an individual is unable to pay their full standard accommodation charge, they can apply to the Department to have their rate reduced, as residents are not expected to spend more than 85% of their income on accommodation. The Department of Health ensures that residents keep at least 15% of their income or an amount not less than $3,126 annually (Department of Health and Wellness, 2017). The province of Nova Scotia has a service eligibility policy and a resident charge policy, both under the Special Homes Act, which determines the eligibility of prospective residents and how much they pay respectively.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

In the early 2000s Nova Scotia developed a longer-term care policy framework for nursing homes across the province, incorporating new public management principles, including competitive bidding for new builds which favoured for-profit companies (Braedley and Martel, 2015).

As part of this shift, the government of Nova Scotia implemented the internationally used standard resident data collection tool, the Resident Assessment Instrument Minimum Data Set Version 2.0 (RAI-MDS 2.0). This instrument offers consistent data collection used to improve the quality of care (Department of Health and Wellness, 2018). However, researchers have criticized the MDS-RAI for inundating workers with paperwork and charting and getting in the way of hands-on care and care relationships (Armstrong et al., 2011; Banerjee et al., 2015).

The Homes for Special Care Act 1989 does not provide specific details about staffing requirements. The 1989 Homes for Special Care Act, the legislation governing long-term care in Nova Scotia, says little regarding staffing requirements. Section 18(2) states:

> In every nursing home and nursing care section of a home for special care where there are less than thirty residents, there shall be at least one registered nurse on duty for no less than eight hours every day, and in the absence of the registered nurse, there shall be a person on duty in the home who is capable of providing emergency care.

and 18(3), “In every nursing home and nursing care section of a home for the aged where there are thirty or more residents, there shall be at least one registered nurse on duty at all times.” (Government of Nova Scotia, 1989)

These requirements say little about appropriate staffing levels or staffing mix, thus long-term care homes have different staffing levels and mixes depending on several factors, including ownership, funding and the care model being utilized. Staffing levels and staffing mix are important aspects of working conditions that have implications for quality of work and care (Armstrong et al., 2020).
The Immigration Policy Context in Nova Scotia

Focusing on the processes by which racialized immigrant care workers enter the long-term care home sector in Nova Scotia, Nova Scotia offers sub-national immigration streams through its nominee programs. The Nova Scotia Nominee Program includes the Nova Scotia Experience (Express Entry), Nova Scotia Labour Market Priorities (Express Entry), Nova Scotia Labour Market Priorities for Physicians (Express Entry), Physician, Entrepreneur, International Graduate Entrepreneur, International Graduates in Demand, Skilled Worker, and Occupations in Demand (Government of Nova Scotia, 2022). Most racialized care workers utilized the International Graduates in Demand and Occupations in Demand streams as pathways to enter Canada. Those two streams specifically seek applicants with work experience in National Occupation Classification (NOC) code 33102, TEER 2, which refers to nurse aides, orderlies, and patient service associates (Government of Nova Scotia, 2022). Additionally, employers in the Atlantic provinces can also use the Atlantic Immigration Program to recruit skilled foreign workers and international graduates from Canadian institutions (Government of Canada, 2022). With these immigration programs in place, Nova Scotia has become one of the important destinations for immigrants in the Atlantic provinces. According to Statistics Canada (2021b), Nova Scotia welcomed a total of 5,035 new immigrants in 2020. This number includes individuals who received permanent residency status, as well as refugees and other immigrants. Generally, immigration policies in Nova Scotia aim at attracting and retaining skilled workers and entrepreneurs and supporting them to integrate into local communities.

Despite the success of these immigration programs, critics argue that these policies encourage the marketization of immigration and the commodification of migrants, with gender, race, and class implications. Dobrowolsky (2011) contends that these provincial nominee programs, including in
Nova Scotia, prioritize economic interests over social welfare. Nourpanah (2019b) has traced a pathway from Ontario, where vocational courses, such as nursing and care aide programs, aim to attract international students who pay high tuition fees. These are often nurses with international qualifications who are pursuing permanent residence, Nourpanah (2019b) found that Nova Scotia employers recruited from these Ontario vocational colleges. This approach results in international students having to pay international fees to work in jobs they were qualified for before entering Canada. (Nourpanah, 2019b).

**Nova Scotia’s Long-term care Union Activity Context**

The vast majority of long-term care workers in Nova Scotia are unionized, whether in for-profit, non-profit or publicly owned facilities. The major unions are the Canadian Union of Public Employees, the Nova Scotia Government and General Employees Union (NSGEU), UNIFOR, and the Nova Scotia Nurse Union. CUPE Nova Scotia has actively campaigned to increase the minimum staff funding for resident care per day for all publicly funded long-term care homes to 4.1 hours (CUPE Nova Scotia, 2019) and for Health Authorities to adopt new funding models to increase staffing levels. Curry (2015) noted that the total hours per resident per day was 3.57 hours in Nova Scotia, which is lower than recommended level of 4.1 hours per resident per day, but higher than in many parts of Canada.

CUPE Nova Scotia has also called for the recruitment and training of more continuing care assistants (CCAs), violence prevention, and health and safety programs to improve working conditions in long-term care homes (CUPE Nova Scotia, 2019). The unions have advocated for a reduction in the cost of tuition fees for the CCA program, which is estimated at $7000.00 (CUPE Nova Scotia, 2019). In a report prepared for the NSNU (2015), fifteen recommendations for long-
term care were made, with an emphasis on legislation changes, increasing the numbers of nurses and nurse practitioners, and an independent inquiry. In 2018, amid pressure from unions, Health and Wellness Minister Randy Delorey convened an expert advisory panel to recommend appropriate staffing levels and skill mix in long-term care homes. The panel made five recommendations and twenty-two action items to be achieved, but progress was interrupted by the pandemic that rocked the sector (Health and Wellness, 2019).

While Nova Scotia continues to actively work to improve its health sector and the long-term care sector in particular, significant challenges in the sector continue to impede progress. These challenges have been at the forefront of union advocacy efforts as highlighted above.

The Ontario Context

Ontario is Canada's most populous province. As of 2018, the population of Ontario was approximately 14.3 million, with 2,462,610 individuals over the age of 65, according to Statistics Canada (2018b). At the time of this research, the provincial government was led by Premier Doug Ford of the Conservative Party of Ontario, who came to power in June 2018 (Government of Ontario, 2018b). The government of Ontario in 2018 had several priorities, including reducing government spending, cutting taxes, and creating jobs (Government of Ontario, 2018c). The province has a diversified economy with major industries in manufacturing, finance, healthcare, and tourism.

Overview

There were approximately 30 long-term care beds per 1,000 population aged 65 and older in Ontario (CIHI, 2021a). Out of the 627 long-term care homes, 57% were owned by for-profit
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

organizations, 27% were owned by not-for-profit organizations, and 16% were publicly owned (CIHI, 2021b).

The involvement of municipalities in long-term care homes in Ontario varies by region, with some municipalities owning and operating their own homes while others contract out to for-profit or non-profit operators. For-profit chains play a significant role in the ownership and operation of long-term care homes in Ontario, with several large chains operating multiple homes across the province (CIHI, 2021b). As of 2018, there was approximately 100,000 staff working in long-term care homes in Ontario, including personal support workers, registered nurses, other health care professionals, such as social workers and physical therapy, and housekeepers, maintenance, food, and laundry workers (Ontario Ministry of Health and Long-Term Care, 2020).

The Long-term care Policy Context in Ontario

In Ontario, the Long-Term Care Homes Act 2007 and the Ontario Regulation 79/10 were the two main legislative instruments that regulated the sector and the care of the over 78,000 residents in long-term care homes across the province until 2022 when the Fixing Long-Term Care Act, 2021 came into effect (Ontario Ministry of Health and Long-Term Care, 2018; Ontario Ministry of Health and Long-Term Care, 2023). The Long-Term Care Homes Act 2007 (LTCHA) came into effect in July 2010, replacing the Charitable Institutions Act, the Homes for the Aged and Rest Homes Act, and the Nursing Homes Act (Daly, 2015; Meadus, 2010). The LTCHA sanctioned a significant shift in the way long-term care (LTC) was regulated and initiated a move towards regulatory and funding parity (Daly, 2015). Regulatory and funding parity guaranteed an equalization of provincial funding to commercial, non-profit, and public providers which brought an end to the preferential grants given to not-for-profit homes. This move allowed for the rise in
for-profit ownership of long-term care homes and public funding of for-profit beds (Baines and Cunningham, 2011a; Armstrong et al., 2011; Daly, 2015). After the debilitating impact of the COVID-19 pandemic, Ontario developed the Fixing Long-Term Care Act, 2021 legislative framework which repealed and replaced the Long-Term Care Homes Act, 2007. The new Act has three core tenets, that is, improving staffing and care; driving quality through better accountability, enforcement and transparency; and building modern, safe, comfortable long-term care homes (Ontario Ministry of Health and Long-Term Care, 2023).

LTC funding in Ontario has gone through many shifts and configurations over the past three decades. Daly (2015) offers a critical historical analysis of long-term care funding in Ontario and concludes that Ontario’s long-term care home sector is one of the most commercialized in Canada in terms of management and delivery. Since the early 1990s, Ontario has pursued a commercial logic in long-term care delivery and management of long-term care homes which has adversely impacted many not-for-profit homes. The daunting reporting requirements resulting from the adoption of new public management principles threatened smaller independent care homes as they could not meet such onerous requirements (Daly, 2015). In 2012, LTC funding was tied to the Resident Assessment Instrument Minimum Data Set Version 2.0 (RAI-MDS 2.0) reporting, which led to a decline in funding for many homes (Daly, 2015). The reporting requirements associated with this instrument also erode care in that staff hours are spent inputting data and not doing the much-needed hands-on care (Armstrong et al. 2011).

Ontario’s LTC planning has focused on building new beds and access to LTC without commensurate policy initiatives to improve working conditions (Daly, 2015). Many of these new beds are in for-profit-owned and operated facilities with a poor record of quality of care (Braedley
This privatization has had adverse effects on the conditions of work and care in long-term care homes and is associated with poor health outcomes for residents (Daly, 2015; Hsu et al., 2016; Armstrong and Armstrong, 2018). For-profit chains have lower staffing levels than other providers (Hsu et al., 2016; Armstrong and Armstrong, 2018), with implications for work organization, employee burnout, work-related stress and injuries, violence, and the overall quality of care.

Ontario has one of the poorest LTC staffing records in Canada. Compared to the rest of Canada, Ontario has 16.4 percent fewer full-time equivalent healthcare staff per resident (CUPE, 2017). This translates to about 3.15 paid hours per day for Ontario compared to an average of 3.67 hours for the rest of Canada (CUPE, 2017). Underfunding is intricately related to understaffing, which also has implications for the quality of care. The annual provincial funding per long-term care bed in Ontario is $43,970.77 compared with the Canadian average (minus Ontario) of $52,185.09 (CUPE, 2017). Unfortunately, the issues of underfunding and understaffing come to the fore when there are deaths and assaults in long-term care, and they are still not policy priorities for the government of Ontario (CUPE, 2017). The staffing mix is another issue. The Long-term Care Homes Act (2007) provides an ambiguous requirement for the provision of care “to meet the assessed needs of residents” and a requirement of one registered nurse (RN) on duty at all times.

The registered nurses’ association of Ontario (2018) asserts that many long-term care homes have kept to this minimum standard set by the LTCH Act (2007), even where the numbers of residents require more nurses on duty, thus compromising the health of residents in long-term care.
The Immigration Policy Context in Ontario

Immigrant care workers seeking to work in Ontario may use the Ontario Immigrant Nominee Program (OINP) to gain permanent residency. Established in 2007, the OINP partners, with the federal government, nominate foreign workers and international students with the necessary skills, experience, and education required by the province (Ontario Ministry of Labour, Immigration, Training and Skills Development, 2019). The program has four main categories including the Human Capital Category, the master’s or Ph.D. Category, the Employer Job Offer Category, and the Business Category, each with sub-categories that fall under them. Prospective candidates can apply for the OINP by receiving an Invitation to Apply (ITA) through the federal express entry system or by submitting an Expression of Interest to the province (Ministry of Labour, Immigration, Training, and Skills Development, 2019).

In the context of this dissertation, immigrant care workers most often enter Ontario through the In-Demand Skills Stream, which falls under the Employer Job Offer Category. Similar to Nova Scotia, this stream specifically includes NOC code 33102, TEER 2: nurse aides, orderlies, and patient service associates. The immigration program provides a pathway to permanent residency for immigrant care workers with a full-time position from an Ontario employer (Ministry of Labour, Immigration, Training and Skills Development, 2019).

According to Statistics Canada (2021b), in 2020, Ontario welcomed a total of 132,995 immigrants. This number includes individuals who received permanent residence status, as well as refugees and other immigrants. In the same year, Ontario was the most popular province for immigrants, with a total of 3,787,470 immigrants living in the province. While the number of immigrants entering Ontario continues to rise, the historical work of Noack and Vosko (2010) and Block...
Noack and Vosko (2010) established in their analysis of non-unionized, low-waged, no pension jobs from 1999 to 2009 that racialized people and immigrants, in particular, were largely employed in precarious jobs. Block (2015) also noted an increase of about 48% in the share of low-wage workers in Ontario from 1997 to 2014 and argued the immigrants were over-presented in these precarious jobs.

**Ontario’s Long-term care Union Activity Context**

Unions in Ontario continue to fight for better working conditions for workers in long-term care homes. The major unions representing Ontario long-term care workers are similar to Nova Scotia and include CUPE Ontario, UNIFOR, the Ontario Nurses’ Association, and SEIU.

At the time of the study, long-term care workers in Ontario were pushing for Bill 13, the Time to Care Act, which would set a minimum care standard of an average of 4 hours of daily hands-on care for residents in long-term care (Canadian Union of Public Employees [CUPE] Ontario, 2018). This bill had previously failed to make it past the second reading at the legislature the last time it was tabled, but CUPE continued to push for the passage of that bill. Without legislated minimum care standards, workers labour under precarious conditions that do not allow them to adequately care for residents (CUPE, Ontario, 2018; Curry, 2015). Improving the quality of care in long-term care homes is one of the main concerns of unions in Ontario. In addition to concerns about understaffing raised in Bill 13, unions are advocating for higher wages and improvement in the quality of care in long-term care homes. Unions have also called for accessible training and certification requirements for long-term care workers and increased funding in the sector overall.
The British Columbia Context

British Columbia is located on the western coast of Canada, known for its natural beauty and diverse landscape. As of 2018, the population of British Columbia was approximately 5.1 million, with seniors (age 65+) making up approximately 18.3% of the population, according to Statistics Canada (2018c). At the time of this research, the province was led by Premier John Horgan, who came to power in July 2017 (Legislative Assembly of British Columbia, 2018).

In 2018, the British Columbia government priorities, included making life more affordable, delivering health-care services in a timely fashion, and improving education, post-secondary, and skills training (Government of British Columbia, 2018). The province has a diversified economy dominated by forestry, mining, tourism, and technology.

Overview

British Columbia has 28 long-term care beds per 1000 population aged 65 and older (CIHI, 2021a). In 2021, approximately 37% of British Columbia’s 308 long-term care homes were owned and operated by for-profit companies, 28% were owned and operated by non-profit organizations, and 35% were owned and operated by public health authorities (CIHI, 2021b). As in Nova Scotia and Ontario, there were concerns about the quality of care in British Columbia’s long-term care homes, including staffing levels, staff training, and pay. The provincial government introduced policy changes aimed at addressing some of these issues, including increasing staffing ratios, and providing additional funding for staff training (Government of British Columbia, 2021). However, concerns about the labour force continue to be an issue in the province.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

**The Long-term care Policy Context in British Columbia**

The health care system is organized differently in British Columbia (BC) than in Ontario and Nova Scotia. Five regional health authorities are responsible for delivering health care services in BC. The Ministry of Health Services and the Ministry of Healthy Living and Sport provide leadership, direction, and support for the attainment of health care goals through legislation, regulation, and policy (British Columbia Ministry of Health, 2016).

Residential care may be provided in a community care facility that is licensed and regulated under the Community Care and Assisted Living Act (British Columbia Ombudsperson, 2009). It may also be provided in an extended care hospital or a private hospital, licensed and regulated under the Hospital Act (British Columbia Ministry of Health, 2019).

The minimum monthly rate for long-term care services is adjusted each year based on Old Age Security/Guaranteed Income Supplement (OAS/GIS) as of July 1 of the previous year (British Columbia Continuing Care Act, 2021). As noted, and quite similar to those in Ontario and Nova Scotia, these assessments are rigorous and embedded in the assumption that individuals may want to outwit the system.

British Columbia long-term care homes have a somewhat complicated legislative and regulatory framework. The legislation and regulatory provisions include the Community Care and Assisted Living Act, Community Care and Assisted Living Regulation, Residential Care Regulation, and the Hospital Act (Longhurst, 2017). Residential care beds in BC are publicly funded and require a charge of not more than 80 percent of the resident’s after-tax income (Longhurst, 2017). That notwithstanding, BC policy has moved toward privatization and a rise of publicly funded beds in for-profit homes since the late 1990s, in lockstep with Ontario and Nova Scotia (Longhurst, 2017).
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

For instance, direct capital funding grants that benefited most non-profit care home operators were halted in the late 1990s, compelling non-profits to turn to private financing for expansion or new buildings (Cohen, 2009; Longhurst, 2017).

Similar to the other jurisdictions in this study, in 2001 the BC government introduced a competitive bidding process for all new publicly funded care home beds (Longhurst, 2017). These patterns of privatization continued with the passage of Bill 29, the Health and Social Services Delivery Improvement Act, and Bill 94, the Health Sector Partnerships Agreement Act, which eliminated provisions that ensured job security and pay equity and provisions that limited contracting out (Longhurst, 2017). Another phenomenon that has emerged out of the move toward privatization is “contract-flipping”; where employers lay-off the existing workforce and re-employ them under more precarious terms, including lower wages and fewer benefits (Longhurst, 2017, p.15).

BC has a lower overall number of for-profit long-term care homes than Ontario or Nova Scotia, but this is changing. Working conditions, as well as the quality of care, are likely to be compromised if this privatization continues, as the profit maximization motive erodes the quality of care (Armstrong et al. 2001; Ronald et al. 2016).

There is no minimum LTC home staffing level or requirements for staffing mix in BC provincial legislation. However, in principle, operators are required to provide care in a manner consistent with the dignity of persons in care (Government of BC, 2009). Where legislation and policies do not provide specific requirements on staffing and staffing mix, operators use their discretion.

The Immigration Policy Context in British Columbia

The British Columbia Provincial Nominee Program (BC PNP) is an immigration program designed and administered by the government of British Columbia’s Immigration Programs
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Branch (Government of British Columbia, 2022). Through this program, the province nominates foreign workers, international students, and entrepreneurs into the province's labor market (Government of British Columbia, 2022). Like every other nominee program, the BC PNP continues to evolve and has designated strategic priorities and initiatives that shape all nomination processes. These new strategic priorities focus on BC’s care economy and technology industry. To meet the growing need for healthcare workers and early childhood educators, BC has given special priority to specific occupations under the National Occupational Classification system (Government of British Columbia, 2022). The registered nurses and nurse aides and other healthcare professionals are given priority through this system. For the purpose of this dissertation, it is pertinent to note that immigrant care workers in BC can apply for permanent residence through this specific stream. BC PNP also works through the federal Economic Mobility Pathways Pilot program to allow employers to recruit talent internationally. Additionally, the province has a Skills Immigration stream and an Entrepreneur Immigration stream. Under the Skills Immigration stream, there is the skilled worker category, healthcare professional category, international graduate category, international post-graduate category, and the entry-level and semi-skilled worker category (Government of British Columbia, 2022). Entrepreneur Immigration allows prospective applicants to choose from three categories to immigrate to British Columbia as an entrepreneur. These categories are the Base category, Regional Pilot, and Strategic Projects category (Government of British Columbia, 2022). With these immigration programs in place, British Columbia is attracting scores of immigrants into its economy. In 2020, British Columbia welcomed 45,680 immigrants, according to Statistics Canada (2021b). This number is very low, due to the conditions of the Covid-19 pandemic. This number included permanent residents, asylum seekers, and other immigrants.
British Columbia’s Long-term care Union Activity Context

The main concern of long-term care sector unions in British Columbia is understaffing. The Health Employees Union (HEU), BC Nurses Union, and other unions assert that there is a need to invest in improving staffing levels and potentially mitigate the shortage of workers in BC’s long-term care sector home. In 2017, the Office of Seniors Advocate reported that most of the care homes in BC did not meet the minimum staffing guideline set by the BC Ministry of Health, which is 3.36 hours per resident per day. According to Longhurst (2017), no for-profit facility met the provincial guidelines in that year. In a care home staffing review, the British Columbia Ministry of Health (2016) acknowledged that meeting staffing requirements was a challenge for many care homes. It is against this drawback that unions successfully campaigned for the election of the NDP provincial government.

Unions believed that the austerity politics of the previous Liberal government had depleted the health care system because of constant funding cuts, so they galvanized support from their members to change the government (Elkins, 2017). The newly elected NDP government, in turn, took an interest in the health care sector and is investing and committing to its improvement. This has been demonstrated in a budgetary allocation of a $548 million into staff recruitment in long-term care, home support, and other services to improve senior care (Hospital Employees Union [HEU], 2019).

HEU reached a three-year collective agreement with the Health Employers Association of BC (HEU, 2019). The agreement covered 44,000 workers from multiple facilities and included violence prevention and work and health provisions as well as a reinstatement of protections against contracting out, which were discontinued by the Liberal government in 2002 (HEU, 2019).
This settlement has been widely considered a success. Despite the gains made so far, the “aging workforce, low-recruitment rates, high incidence of worker burnout and injury, funding challenges, and the increasing acuity level of seniors” has culminated into what has been called the “perfect storm” of issues challenging the sector (BC Care Providers Association, 2018, p.2).

**Concluding Thoughts**

In this chapter, the complexity of policies, regulations, and legislation that govern the delivery of care in long-term care homes across the three provinces has been outlined. Each province implements some form of regionalization with varied structural configurations because of variations in population size and land mass. Despite these differences, there are remarkable consistencies affecting working conditions across these policy contexts. Policy direction towards privatization remains consistent across all three provinces, although it differs somewhat in the depth and speed of this shift. The move to deepen privatization has dire implications for the conditions of work and, consequently, the conditions of care. While immigration policies have focused largely on attracting immigrants with the required skills to fill in the employment gaps, the main challenges in the long-term care sector are yet to be sufficiently addressed in all three provinces. Union advocacy efforts in all provinces in this project have highlighted the need to invest in staffing levels and wages and improve access to training and certification.
Chapter 4: Project Design and Methodology

This project emerged out of my participation as a doctoral trainee on a long-term care home research project led by Dr. Janice Keefe (Mount Saint Vincent University) and funded by the Canadian Institute for Health Research (CIHR), called SALTY (Seniors Adding Life to Years). A multi-method research project, this large national study included over 30 researchers, decision-makers, clinicians, long-term care home workers, residents, and family representatives. This project’s co-investigators included many of Canada’s most recognized experts on long-term care home policies and practices, including Carol Estabrooks, Pat Armstrong, Hugh Armstrong, Tamara Daly, and Susan Braedley.

My participation was with a sub-team from SALTY: a small ethnographic team that focused on mapping care relationships to identify and analyze promising relational approaches to care in long-term care homes. These promising relational approaches were defined as approaches to care relationships that ensured that residents, workers, family members, and volunteers were treated with dignity and respect. Relational approaches to care place value on care relationships among the constellation of people who work together to provide care to residents. The interdisciplinary ethnographic team was composed of social science and health science researchers affiliated with four universities in Ontario and Nova Scotia who were differently situated in terms of their academic trajectories and experience. Four of the researchers on the stream have studied Canadian long-term care homes for over a decade and collaborated on other research projects, including three white women and one white man.

I was fortunate to be able to collect independently the majority of the data presented in this dissertation that form the basis of my findings and analysis. However, to build context, I drew on
data that we collected as a team. While we collected data on promising approaches to care in late life with a focus on the quality of life, quality of work, and quality of death, we attended to a wide array of issues that constrain or improve care, of which racialization and culture were pertinent components. The topic emerged from our field work observations and conversations with workers and each other, and my participation on the team as an immigrant, racialized graduate student was part of this dynamic.

As a Black researcher, the experience of using a Westernized research framework, which is arguably oppressive, to garner information from racialized care workers, was unnerving. The discomfort and tension racialized care workers felt in our conversations were partly due to the experience of “being researched”. Though I tried to assert my positionality and identity as a caveat through which I could create some comfort with the discomfort, it was apparent that the research venue was a significant challenge. “Being researched” at a place of work is not necessarily appealing, but “being racialized and researched” is a case of double jeopardy, despite the liberating tenets that shaped our research project. Also, as a racialized man in a female-dominated work environment seeking to engage with racialized women and men, I was intentional about my approach to inquiry. I proceeded with humility, respect, and optimistic caution. I was aware that gender roles and expectations differ culturally, so I was careful not to assume the researcher tag on my shirt or my racialized identity gave me the legitimacy to engage. I ensured that my tone of voice, facial expression, posture, and non-verbal cues communicated, politeness, respect, humility, and a willingness to listen and learn.

Rapid team-based ethnography is a collaborative research process that triangulates evidence from interviews with observations, secondary data, and experiences of researchers in the field
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

(Armstrong and Armstrong, 2018). The team-based nature of this approach to inquiry meant there were constant corroborative conversations and debrief sessions. Although being a team is a great approach to research, being one of two racialized members of the team, and the only racialized male and doctoral student on a team of both well-established and emerging academics presented some challenges as the team dynamics unfolded.

Despite the fact that the team members were friendly and kind, being in the company of academics of that pedigree alone was quite intimidating. The fact that almost all the researchers were white, and the other racialized researcher was a naturalized Canadian also made it difficult to identify more freely with the team. In team debrief sessions, when conversations unfolded, I experienced within me significant tension, especially when I had contributions to make to ongoing discussions. Discussions were fast paced as researchers sought to build a narrative from observations and make sense of the data. From time to time, I was invited to share my perspectives during debrief sessions by my team. Understandably, my team was concerned about my silence as I struggled to find myself in the group dynamics.

While this was good for me as a beginner who was being trained on the job, it was quite discomforting as it gave me too much audience - akin to a feeling of being set on a platform to offer a speech. I would have appreciated more organic ways of approaching conversation and perhaps a slower pace; however, many of these researchers had worked with each other or could adapt to the pace of the conversations. The caveat was that I had the opportunity to work with almost all of them as partners during interviews and observations, which gave me the opportunity to garner their thoughts on several issues related to my specific interest in race and racialization and share my ideas with them.
Notwithstanding the adverse challenges experienced in the research field, I was able to appropriate myself, a Black man, as an instrument. I used my Blackness to identify with racialized care workers at the research sites. My Blackness afforded me an entry point that would have otherwise been difficult to achieve. I was able to convey to racialized care workers the pertinence of their perspectives on the research project. This project, with its social justice concerns, received some buy-in from racialized care workers once they understood the goal of the study. On the other hand, I am a man and a doctoral student. While I have engaged in low-waged work, I have not been a care worker. While my colleagues could draw on their personal and professional experience in long-term care homes and/or their gendered positions as women-in-families and households to create meaningful connections with workers, I was continually negotiating my masculinity and perceived class position.

This research team conducted rapid ethnographies in eight long-term care homes across four jurisdictions. The team data collection was an iterative and collaborative process. The study took place in four Canadian provinces (Ontario, British Columbia, Nova Scotia, and Alberta). Within each of the four provinces, two facilities were purposively selected, guided by Canadian Institute for Health Information (CIHI) data on falls and population size or their rural and small-town status. This dissertation project draws on the data collected in six homes in three jurisdictions, leaving out Alberta, which was completed after this dissertation was underway.

**How I Situate my Research**

Cognizant of the opportunities and limitations of locating my dissertation in another study, I had extensive conversations with my research team, and team leads to clarify the focus of my dissertation at the onset of the research project. After understanding the core tenets of my study
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

and its intersections, as well as its distinctiveness from the SALTY ethnographic study, the team collectively pledged their support for my study and acknowledged its timeliness. Though this dissertation is entirely independent, my ideas were influenced by conversations with astute researchers on the project.

The SALTY ethnographic study collected a robust set of data with an overall focus on the quality of life, quality of work, and quality of death, with specific attention to gender, race, culture, and in long-term care homes. My dissertation focused mainly on racialization and working conditions. To ensure my research questions were answered adequately, I actively participated in all site visits, purposively interviewed racialized care workers in each home, and made careful field observations about conditions of work, the physical environments, and expressions of dominant and subordinate culture in each home. The interviews I conducted and the observations I made in the research field formed the basis of my independent analysis presented in this dissertation. The research questions emerged from my initial experiences in the broader research and through the rich conversations and interactions on the field with the team of researchers and workers.

Methods

The qualitative research method used was (rapid team-based) ethnography. Ethnography as an approach to qualitative inquiry allowed for the observation of the everyday activities and practices of research participants in their natural context (Sands, 2013). Also, ethnography requires researchers to immerse themselves deeply in the sights, scenes, textures, and culture of participants whilst remaining cognizant of their own positionality (Sand, 2013). Under the broad umbrella of ethnography, the specific method utilized was rapid team-based ethnography.
Rapid team-based ethnography is a “multi-method ethnography involving data collection from numerous sources over a relatively short period of time including interviews, participant observations, document review and sometimes surveys and focus groups” (Baines and Cunningham, 2011b, p. 74). It is mainly undertaken by a team of researchers in a relatively short but intensive period of time (Baines and Gnanayutham, 2018). Team-based ethnography provides a robust textured analysis of everyday life experiences by contextualizing them in the social, economic, and political milieu that shapes them (Baines and Cunningham, 2011b). Team-based rapid ethnography allows for an iterative research experience with possibilities for the interdisciplinary enmeshment of ideas and the consistent recalibration of research strategies (Baines and Gnanayutham, 2018). This approach to inquiry was particularly useful because gender, race, class, and other social relations we sought to uncover and explore are complex and impacted by multiple factors. This method also allowed for first-hand experiential learning and training of novice academics on a research project through “multiple dialogues among team members” (Armstrong and Armstrong, 2018, p.1). It was beneficial for me as a new researcher as I had the opportunity to learn from experienced researchers.

**Data Collection Methods**

Consistent with the team-based rapid ethnography approach, the research team began by collecting, reviewing, and analyzing extensive background data on the specific long-term care home and its regulatory, population, and socio-economic context. Next, the team collected observational and key informant interview data during a five-to-six-day intensive site visit with a team of 5-7 researchers who observed, participated, and interviewed across the home from early morning to mid-evening when residents were concluding their day, and workers for the night shift are arriving (Baines and Gnanayutham, 2018). In this study, the team also generated a
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

photographic record to consider how the physical environment supported quality care. The photographs did not include any people other than our research team members, due to our ethics protocols. Photographs were taken of the buildings, interiors, food, artwork, furnishings, activity supplies, gardens and outdoor areas, kitchens, laundries and staff areas. The photos were not taken with a purpose other than to record the physical environment so that team members could check on their memories and triangulate data findings from field notes and interviews. While I participated in all these activities within the six prospective research sites, I also purposively recruited racialized care workers because of my interest in understanding their experiences on and off the job and their implications for care. I immersed myself in the milieu of each facility and attentively observed the scenes, sights, smells, and events as they unfolded.

As part of the team, I recorded observations in field notes and synthesized them through thorough debrief sessions and process conversations. I utilized the snowballing technique to recruit participants for my study. My assumption was that racialized care workers knew each other through informal associations at the workplace. Thus, I asked participants to provide leads on potential participants who may be interested in the study and followed their lead. Finally, to the extent possible, I sought to ensure there was diversity among the participants I selected, considering their gender, culture, occupational level, country of origin, and immigration status. The specific data analyzed for the dissertation include:

1) In-depth interviews with 18 racialized immigrant care workers.
2) Management interview discussions involving 18 senior management team members.
3) Field notes taken from weeklong observations at each of the six research sites.
4) Photographs taken of the physical environment, food, artwork, and more.
Entry Strategies

Research site entry strategies are important in qualitative research (MacDonald, 2018). In a highly medicalized and controlled sector such as long-term care, it becomes more crucial. The team leads organized entry, holding meetings with managers prior to our site studies, and providing materials to share with staff, residents, and families about our site visit well in advance. In some cases, team leads had also spoken with family councils, union representatives, and others involved at the home prior to the site visit. To understand and appreciate the context of the study, SALTY team members collected and reviewed background information for the selected LTC care homes before site visits. As a team member, I reviewed each facility’s history, policies and philosophies of care, web posts and advertisements, reports, and publications about the facility and the facility’s community. This review process gave me an initial idea of the context of the facility before the site visit.

Entering a long-term care home was the first layer of access; however, to recruit prospective participants for my study, I had to negotiate several access points. The SALTY team received an official introduction to the facility from the management of every research site. These introductions included a meeting with available management team members and walkarounds to show us different parts of the care home.

During management meetings, I listened attentively and asked questions about the nature of diversity among the workforce in the facility. After the meeting, where possible, I identified and engaged with the individual responsible for scheduling at the facility. My interest was to find out the number of racialized workers at the facility in general and, more specifically, the number or racialized care workers who would be on shift during our site visit. With these numbers in hand, I went through the facility knowing where to look and whom to look for. This only served as an aid,
as availability depended on the nature of their shift. Below, I review information on each research site in this study.

**Study Sites**

The study sites for this project were strikingly similar overall, despite their distinctive characters, culture, and aura. There were also similarities and differences in how the racialized immigrant workers in these homes had entered Canada, their countries-of-origin, and their paths to long-term care work. For instance, most of the racialized care workers I met in Nova Scotia had moved from Ontario after completing their studies for permanent residence. Once they arrived, they worked and then applied with their work experience through the Atlantic Pilot Program (Nourpanah, 2019b). The majority of the racialized care workers at the Nova Scotia facilities we visited were from India. The group in the Ontario sites was more diverse in terms of both their immigration pathways and countries of origin. They included those who had entered Canada under the Live-in Caregiver immigration program and had transitioned into long-term care work, refugee claimants, and those who had come as international students and graduated from Ontario Colleges, among others. This group of care workers were mainly from the Caribbean, Philippines, India, and other parts of Asia.

The group of racialized care workers in British Columbia were mainly from the Philippines and had transitioned from the live-in caregiver program to work in long-term care homes. Also, the number of racialized care workers in these rural and small-town long-term care homes in Nova Scotia were significantly larger than in Ontario and British Columbia. Opportunities for permanent residence could have played a role in Nova Scotia, while in Ontario and B.C., the employment
opportunities and large immigrant populations in these provinces’ large urban areas offer alternatives to rural and small-town settings.

Additionally, a significant number of workers had grown up and always lived in these communities and knew residents and each other outside their workplaces. Also, in Nova Scotia, unlike in Ontario and BC, the hours of work (Shift) were longer. At the time of the study, care workers in Nova Scotia worked 12-hour shifts, whereas those in Ontario and British Columbia worked eight-hour shifts. In all facilities it was not unusual for workers, especially racialized care workers, to do double shifts.

Each home used a care model with some influence from care philosophies like The Eden Alternative® Philosophy (The Eden Alternative, 2021). These care models shaped the care experience in these homes and gave them a distinct outlook in terms of its programming and resident engagement. Finally, facility ownership was similar across jurisdictions. In Ontario, one of the homes was private-not-for-profit, whereas the other was municipally owned. In Nova Scotia, one of the facilities was private, not-for-profit, and the other was municipally owned. In British Columbia, one of the facilities was a private not-for-profit, and the other was run by a Regional Health Authority. These homes had been purposively selected, leading to their similarities.

The contextual differences and similarities impacted the work organization, work intensity, and channels of communication at the long-term care homes. The stories about the conditions of work, violence at work, and the invisibility racialized care workers experienced, however, were strikingly similar across jurisdictions. Long-term care work is hard work, and there is not enough support for workers who labour to support vulnerable residents at the frontlines.
In what follows, I present detailed descriptions of each study site. Our research ethics protocol requires me to anonymize the details of the specific homes, so approximations, rather than specific numbers and locations, are offered below.

**Ontario Study Sites**

We visited these facilities from April 12 to 20, 2018. The first long-term care home we visited in Ontario was located in a town with a population between 26,000 to 29,000 people (Statscan, 2016) and a land area between 67 km$^2$ to 70 km$^2$. The area had seen significant growth over the past decade, but despite the population growth, the town maintained its small-town character. The local parks, green spaces, and trails made for a beautiful natural environment. The major industries in the area are farming and manufacturing, tourism, and agriculture. The immigrant population in this town was between 14% and 17% of the population, and the visible minority population was between 4% and 7% (Statscan, 2016).

The long-term care home we visited in this town was not-for-profit and affiliated with a religious community. Most of the population at this home was first- and second-generation European immigrants who were members of a distinct faith community. Like some long-term care homes, this facility was located on a campus that included assisted living apartments. The home claimed to offer care in a compassionate religious setting. This home had a significant volunteer base, many of whom were connected to the faith community affiliated with the home. Most of the community engagement in this home was funneled through the religious community with individuals of a specific European ancestry. Incorporated in the mid-20th century, parts of this long-term care home were rebuilt in the early 21st century, and presently it has between 100 and 160 beds. The home has about 90 private rooms and about 25 semi-private or double occupancy rooms. The home
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

had a structured volunteer program with over two hundred active volunteers supporting it regularly. Staffing levels were not adequate, and the home was actively recruiting workers at the time of our visit. Most openings were for part-time or casual work. The facility is a culturally specific home, so it aims recruitment efforts at care workers who share the culture of residents at the facility. Consequently, immigrant, racialized care workers form a small proportion of the percentage of workers at this facility, although many white workers and managers were recent immigrants. The long-term care home was unionized, with more part-time and casual staff than full-time staff.

The second facility was in a town with a population that ranged between 4000 and 7000 people (Statscan, 2016) and a land area that ranges between 4km² and 7km². The area boasts natural attractions and festivals that bring vibrance to the town. The town is also closely connected to its agricultural communities. The largest employer is the manufacturing industry which accounts for 16% of all employment in the county within which the long-term care home is located. The immigrant population in this town is between 7% and 10% of the population, and the visible minority population is between 1% and 4% (Statscan, 2016).

This long-term care home was municipally owned and operated. Originally built in the early 20th century, this facility was rebuilt in the early 21st century. The facility has between 100 and 150 beds with four integrated units. The home has about 60 shared rooms and about 20 private rooms. The home offers a diverse range of activities, including pet therapy and computer-based programs to improve resident’s emotional, social, and cognitive wellbeing. The home utilizes a structured care model that informs recreational activities as well as the ways in which the home sets up common areas. Volunteers from the community were actively involved in many aspects of the
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

home, running a small shop and assisting residents in running a small coffee stand, as just two examples. Staffing levels were higher than in the other Ontario home, and racialized immigrant care workers described that they enjoyed the collegiality and inclusiveness at this home. The long-term care home is unionized, with more part-time and casual staff than full-time staff.

**Nova Scotia Study Sites**

The third long-term care home we visited, from July 25 to 29, 2018, was in Nova Scotia. It is located in a town that covers a geographical area of between 2km² and 5km² with a population ranging between 1,000 and 4,000 people (Statscan, 2016). Its strategic location, sights, and scenery makes the town a beautiful tourist destination. It is also known for its historic buildings, architecture, and heritage, which have been preserved over the years. The major industries in the region are agriculture, forestry, fishing, and hunting. These industries account for 17% of the labour force in the region. The immigrant population in this town is between 2% and 5% of the population and the visible minority population is between 1% and 4% (Statscan, 2016).

The long-term care home we studied was incorporated by the municipality in the late 20th century. At that time, it was part of a local hospital; however, after several decades of expansions and transitions, a replacement building was established. Presently, the long-term care home has between 80 and 110 beds, with one of those beds serving as a respite care bed for the community. The rooms in this care home are private. The home is designed to have a home-like feel and appeal. Each of its home unit areas has 11-12 resident rooms and has its own kitchen, dining area, living room space, and laundry room. The facility claims to be a comfortable, healthy, pleasant, and compassionate place to live and work. Staffing levels were relatively higher than those on the
The long-term care home is unionized, with more part-time and casual staff than full-time staff.

We visited the second long-term care home in Nova Scotia from Sept 19 to Sept 23, 2018. The town covers a land area of between 3km² and 6km² with a population between 1,000 and 4,000 people (Statscan, 2016). The town’s major industries are retail trade and manufacturing, with a growing service industry, particularly in the health care and education sectors. This area is also widely known for fish processing in Canada. The immigrant population in this town is between 9% and 12% of the population, and the visible minority population is between 0.9% and 3% (Statscan, 2016).

This long-term care home is a not-for-profit facility built in the late 20th century that is run by the government of Nova Scotia. It is one of the major employers in the town and boasts a competent mix of professionals dedicated to providing quality care in the region. Like other long-term care homes in the region, this facility depends on a growing number of volunteers to provide care for residents. Volunteer opportunities have a latent function that connects the community to residents. The facility has four units with between 120 and 150 beds, with variations across the units. The care home has about 25 private rooms and about 60 shared rooms. This home had the highest number of immigrant care workers of all the sites visited in the study. Most of the immigrant care workers had accessed permanent residency through the Atlantic Immigration Program. The long-term care home is unionized, with more part-time than full-time staff.

**British Columbia Study Sites**

The fifth and sixth long-term care homes included in this study are located on Vancouver Island, British Columbia, and were studied consecutively from January 14 to 22, 2019. The first of these
homes is in a town with a population that ranges between 33,000 and 36,000 (Statscan, 2016). The location has a variety of industries and businesses and covers a land area of between 120 and 150 km$^2$. Retail services, health care and social assistance, and agriculture, fishing, engineering, manufacturing, and forestry are the major industries in the area. The immigrant population in this town is between 8% and 11% of the population, and the visible minority population is between 3% and 6% (Statscan, 2016).

This long-term care home has between 80 and 110 private care beds and between 3 and 6 hospice beds. This facility is subsidized by Island Health, and the organizational structure in the facility allows for significant control by Island Health. The facility has six units physically structured in three overall zones. Rooms are grouped into zone-like spaces called cottages with living, dining, and socializing areas. All rooms at this care home are single occupancy rooms. Staffing levels were relatively higher than those on the Ontario sites though less than the recommended 4 hours. The long-term care home is unionized, with a significant number of full-time staff relative to the other sites.

The other home is located in a town with a mix of urban and rural settlements in a vibrant community context. The population of the town ranges between 10,000 and 13,000 (Statscan, 2016). The town covers a land area ranging between 12km$^2$ and 15 km$^2$. The town is a major tourist destination because of its beaches and scenery. Tourism contributes immensely to the economy of the town. Apart from tourism, retail trade, health care and social assistance, construction and business, financial and administrative industries are major industries in the town. The immigrant population in this town is between 15% and 18% of the population, and the visible minority population is between 3% and 6% (Statscan, 2016).
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

This sixth long-term care home includes an assisted living facility on its premises and maintains an active connection to the community. The home has between 60 and 90 publicly subsidized beds with a respite room. Rooms in this facility are private or single occupancy rooms. First opened in the late 20th century through a collaborative community initiative, a new bigger building was constructed close to the old building in the 2000s. The new building replaced the old one, which now serves as an assisted living facility. The facility also runs day programs and offers respite spaces as well.

The facility is close to the town center and offers proximity to recreational and other amenities in the town. The facility utilizes a care model that allows in-house pets as well as pet visitations to make life meaningful and enjoyable for residents. The home’s physical layout is designed to invite natural light into its five main home areas and sitting areas. Rooms are also designed to include windows that view the grounds or the courtyards. Staffing levels and direct care hours at this facility were relatively high. There were more full-time staff compared to the other sites visited.

**Study Participants**

While I interviewed many people for this study, this analysis draws on specific interviews with 18 immigrant, racialized staff across these six homes, with at least two interviews at each home. The chart below describes these workers in brief.

<table>
<thead>
<tr>
<th>Province</th>
<th>Position</th>
<th>Gender</th>
<th>Number of years worked</th>
<th>Country of Origin</th>
<th>Residency status</th>
<th>FTE</th>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>ON</td>
<td>Dietician</td>
<td>F</td>
<td>16</td>
<td>India</td>
<td>Citizen</td>
<td>PT</td>
<td>Dietician</td>
</tr>
</tbody>
</table>
Interviews with care workers were all approximately one hour in length and were conducted by me and, in most cases, one other team member. Interviewing in pairs is part of the rapid ethnographic method. This protocol aims to enhance team learning by allowing for multiple perspectives while also ensuring safety for both interviewees and interviewers. Out of the 18 racialized care workers interviewed, 12 were front-line care workers responsible for providing intimate care, including activities of daily living like bathing, toileting, and feeding, as well as

<table>
<thead>
<tr>
<th>ON</th>
<th>BSO&amp;RPN</th>
<th>F</th>
<th>15</th>
<th>Jamaica</th>
<th>Citizen</th>
<th>PT</th>
<th>Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>ON</td>
<td>PSW</td>
<td>F</td>
<td>7</td>
<td>Philippines</td>
<td>Citizen/PR</td>
<td>FT</td>
<td>Midwife</td>
</tr>
<tr>
<td>ON</td>
<td>PSW</td>
<td>F</td>
<td>11</td>
<td>Bosnia</td>
<td>Citizen</td>
<td>FT</td>
<td>Hotel Receptionist</td>
</tr>
<tr>
<td>ON</td>
<td>RPN</td>
<td>F</td>
<td>8</td>
<td>India</td>
<td>Citizen</td>
<td>PT</td>
<td>RN</td>
</tr>
<tr>
<td>ON</td>
<td>RN</td>
<td>F</td>
<td>3</td>
<td>India</td>
<td>PR</td>
<td>FT</td>
<td>RN</td>
</tr>
<tr>
<td>NS</td>
<td>SS</td>
<td>F</td>
<td>8 months</td>
<td>Canada</td>
<td>Citizen</td>
<td>PT</td>
<td>SS</td>
</tr>
<tr>
<td>NS</td>
<td>CCA</td>
<td>F</td>
<td>-</td>
<td>-</td>
<td>Citizen</td>
<td>PT</td>
<td>-</td>
</tr>
<tr>
<td>NS</td>
<td>CCA</td>
<td>M</td>
<td>2</td>
<td>India</td>
<td>PR</td>
<td>PT</td>
<td>RN</td>
</tr>
<tr>
<td>NS</td>
<td>CCA</td>
<td>M</td>
<td>1</td>
<td>India</td>
<td>PR</td>
<td>PT</td>
<td>RN</td>
</tr>
<tr>
<td>NS</td>
<td>RN</td>
<td>F</td>
<td>4</td>
<td>India</td>
<td>PR</td>
<td>PT</td>
<td>RN</td>
</tr>
<tr>
<td>NS</td>
<td>LPN</td>
<td>M</td>
<td>3.5</td>
<td>India</td>
<td>PR</td>
<td>FT</td>
<td>RN</td>
</tr>
<tr>
<td>BS</td>
<td>HCA</td>
<td>F</td>
<td>12</td>
<td>Philippines</td>
<td>Citizen</td>
<td>C</td>
<td>RN</td>
</tr>
<tr>
<td>BS</td>
<td>HCA</td>
<td>F</td>
<td>10</td>
<td>India</td>
<td>Citizen</td>
<td>FT</td>
<td>RN</td>
</tr>
<tr>
<td>BS</td>
<td>HCA</td>
<td>F</td>
<td>1</td>
<td>Philippines</td>
<td>PR</td>
<td>PT</td>
<td>-</td>
</tr>
<tr>
<td>BS</td>
<td>HCA</td>
<td>F</td>
<td>6</td>
<td>Indigenous</td>
<td>-</td>
<td>FT</td>
<td>-</td>
</tr>
<tr>
<td>BS</td>
<td>HCA</td>
<td>F</td>
<td>10</td>
<td>Philippines</td>
<td>Citizen</td>
<td>FT</td>
<td>RN</td>
</tr>
</tbody>
</table>
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

emotional care (Storm, Braedley, and Chivers, 2017). In Ontario, these workers are called personal support workers; in Nova Scotia, they are called continuing care aides; and in British Columbia, they are health care aides. Four of the remaining care workers were registered practical nurses, and two were registered nurses. Registered practical nurses (RPNs) focus mainly on the provision of medical care, like administering drugs, monitoring health status, and maintaining clinical records. RPNs reported directly to RNs who oversaw the floor. Of the 18 racialized care workers who participated in the study, 4 were men, and 14 were women. This is consistent with the assertion of authors who argue that direct care in long-term care is feminized work (Banerjee et al., 2008; Storm, Braedley, and Chivers, 2017). While this sample of workers is small, it is all representative of the numbers of racialized immigrant workers in these settings. These workers were often the only racialized worker on a shift across an entire facility.

Management Interviews

In each setting, the entire research team conducted a group interview with managers to learn about the governance, finance, management approach, labour force, resident population, and the home’s approach to care. These interviews were sometimes with just the Executive Director and sometimes with a group of managers. The group of managers included dietary managers, managers in charge of maintenance, Unit managers, Clinical managers, and others. Of the six managers or Executive Directors of the homes, five were women, and one was a man. Also, of the five women, one was a racialized naturalized Canadian of Asian descent.

Field Notes

The interviews were complemented with field notes from hours of field observations, which are included in the data analysis. The numbers of racialized workers in some of these homes were
small, and the relationship between small numbers and experience is what I was interested in researching. Field notes also commented on the conditions of work and care, including food, physical environment, laundry and clothing, housekeeping, activities, visitors, worker routines and relationships and much more. The goal was to provide thick descriptions of the conditions and experiences of differently situated racialized workers in long-term care homes.

**Data Analysis**

The data used in this study includes the eighteen interviews noted above, my field notes and observations, and photographic records. Data analysis for the interview and field notes from this study was inspired by Braun and Clarke’s (2013) flexible thematic analysis approach. Braun and Clarke (2013) propose a six-phase analysis framework that includes familiarization with data, coding, searching for patterns, reviewing, and revising the themes, defining and naming themes, and developing the analysis. This method of analysis allows researchers to immerse themselves in field data and establish patterns of meanings as they emerge from complex, contradictory relationships embedded in data. Under this method of analysis, pattern recognition and identification is guided by research questions. Field data for this dissertation was transcribed by professional agencies as part of SALTY stream 2’s data transcription process.

Once interviews were professionally transcribed, the data was made available to researchers through a password-protected database. For the purposes of my dissertation, I read and reread interviews conducted with management and racialized care workers, and field notes multiple times to familiarize myself with the data in accordance with Braun and Clarke’s (2013) thematic analysis model. In the coding stage, I generated codes with leads from my research questions.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

My emphasis at this point was on lived experiences, navigation of white spaces, and the conditions of work. Following that, I searched for themes that reflected patterns as they emerged from the codes identified. The goal at this point was to develop larger patterns across the data. The themes developed at this point were provisional and were revised through ongoing analysis (Braun and Clarke, 2013).

Afterward, I reviewed and revised the themes to ensure that they were aligned with the research questions and took into consideration complexities and contradictions in the data. Here, I went back to coded data and generated themes to ascertain if the themes adequately covered the coded data in relation to research questions, and the needed tweaks were made to ensure clarity and flow. During the defining themes phase that followed, my goal was to clearly articulate my themes and to communicate their distinctiveness and specificity. This phase also allowed me to reflect on the scope of each theme, write theme definitions and develop an inclusion and exclusion criteria.

At the final stage, developing the analysis, I developed thick and rich descriptions and located my analysis within the context of extant literature, identifying points of convergence and departure. I selected parts of the verbatim transcriptions that clarify the theme and potentially tell the reader a story and make a real argument in support of the findings (Foster and Parker, 1995; Braun and Clarke, 2013).

Additionally, I conducted an independent analysis of pictures taken by the research team and I during research site visits. A significant number of the pictures reviewed for this analysis were taken independently at the research sites. These pictures were used as memory devices to corroborate field notes and allowed me to make meaning of whiteness as expressed symbolically and in physical environments. My goal was to understand how the working environments captured
were relevant to the everyday life experiences of racialized immigrant care workers. Out of the hundreds of pictures taken at research sites, I purposively selected forty of them for my analysis. Taking inspiration from Pink’s (2021) discussion of photographic analysis in ethnographic studies, I describe the pictures used in my analysis, analyze pertinent visual elements, and deduce meaning guided by my research questions.

Concluding Thoughts
This chapter elucidates my participation in a multi-disciplinary sub-team under the SALTY project and how I worked independently and collaboratively with the team to collect data for my project. The team aimed to identify and analyze approaches to care that ensured dignity and respect for residents, workers, family members, and volunteers. The topic of the research emerged from my fieldwork observations and conversations with workers and participation as an immigrant and racialized graduate student. While participating on the team, I collected most of the data for my dissertation, but also drew on the team's data for context. The team's research explored various aspects of care in late life, including quality of life, work, and death, while also considering factors such as racialization and culture. As part of the team, I focused on the experiences of racialized care workers, exploring themes of racism, racialization, and culture. I was also aware of my positionality as a Black racialized man in a female-dominated workplace and approached the study participants with optimistic caution and respect, allowing them to lead the conversations that form the core of my research.
Chapter 5: Working in White Environments

Whiteness was a key feature of all the long-term care homes in the rural and small towns included in this study. In this chapter, I argue that immigrant care workers work in white environments in rural and small-town long-term care homes. These environments are distinct from their culture, language, and values and are not designed to include, recognize, or welcome them. I demonstrate that white environments and spaces further perpetuate the othering of racialized care workers as they are recruited to fit in without support. Finally, I argue that white environments in long-term care homes validate white dominance and work to other immigrant care workers in the organization of space and in the presentation of cultural cues, food, smell, and images that may hold memory and have a lasting effect on people.

The whiteness of study sites was palpable as alterity was produced, felt, and observed in them. Whiteness in the Canadian context, in general, is about settler relations of dominance and unequal power relations (Frankenberg, 1997; Coulthard, 2014). It is about white people and the privileges they enjoy at the expense of others (Levine-Rasky, 2013). White values pass as neutral, race-less, and unremarked as they become the standard against which all other values are measured and racialized (Frankenberg, 1997).

The neutrality of whiteness is a testament to its dominance in social structures and relations (Dyer, 2017). Exploring white spaces in this dissertation allowed for the questioning of commonly taken-for-granted expressions of dominance both symbolically and discursively in space. Dominance also manifests itself in colour-blind ideologies that support the privileged positions of white people and disregards the subjugated positions of racialized people (Rankin-Wright, Hylton, and Norman, 2020). Guided by critical whiteness studies, I unpacked the many ways whiteness was implicitly
and explicitly embedded in the environments of long-term care homes. Below, I create a depiction of whiteness from photographs taken by the research team and my field notes made during our research site visits to question the idea of home-likeness and the dominant perspectives that shape long-term care. I also parse out the implications that food, physical space, and racialization could potentially have for social relations in long-term care homes.

**Picture Analysis: A Portrait of Whiteness**

In what follows, I explain “whiteness” as an intrinsic quality of the long-term care homes in this study by analyzing the photographic record produced by the research team at each site. Here, I present both an independent analysis of photographs taken at each research site and an analysis of the pictures and artifacts in the long-term care home, as recorded in our photographic record.

As a team of researchers, we used photography as a corroborative tool and an aide-memoire to check on our observational notes to ensure accuracy and fact-checking. The photographs used in this dissertation were taken by the research team and I as we observed field research sites. Due to our ethical obligations, we did not take photographs of people during the field research but of the research environment, including the “memory boxes” or personal displays of residents’ objects and pictures outside each resident room, the dining rooms and other communal areas, the walls, decorations, organization of space, food, outdoor areas, building entrances, workspaces, including laundries, kitchens and utility areas, and staff rooms.

These photographs reveal the operation of whiteness in long-term care homes, providing evidence of values, cultures, traditions, and ideologies that shape the long-term care space symbolically, discursively, and in practice (Hight and Sampson, 2004). Upon analysis, these photographs reveal the historical and cultural construction of whiteness as a social category that is created and
maintained through everyday practices and power relations (Dyer, 2017). They offered evidence of how long-term care homes might be inclusive or exclusive, inviting or rejecting, welcoming or cold.

Beyond this analysis of the environment depicted in the team photographic record, I also analyze the photographs of pictures, photos, and artifacts in these photos. According to Bohnsack (2010), “an understanding through pictures means that our world, our social reality, is not only represented by but also constituted or produced by pictures and images” (p.269). Together, pictures, photos and artifacts displayed in the long-term care homes offer an interlocutory point where lived realities are simultaneously shaped, produced, and reflected.

**Long-term Home Care (Home for Whom?)**

Long-term care policies and settings often promise atmospheres that approximate a look and feeling of home-likeness (Braedley and Martel, 2015). Though “home” itself, with its individual, idiosyncratic, and peculiar nature, cannot be approximated for a group of people with disparate life histories, the idea of home is a cliché that many long-term care homes try to model and, in some cases, denote as part of their mission. A viable alternative could be the consideration of the long-term care home space as a communal space or community where residents, workers, and families engage in multiple social relations and connect at least on the level of a shared humanity (Braedley, 2018). This alternative does not sensationalize the long-term care home settings but embraces its messiness, disruptions, and disorderliness as the community forges ahead in an inclusive manner.

“Home” as an idea that shapes the organization of long-term care homes has been contested and problematized on multiple levels (Braedley and Martel, 2015). The insistence that long-term care
is home for residents has been resisted because, indeed, it is not home, nor is it experienced as such (Adams and Chivers, 2017). The fact that long-term care homes may be designed to be comfortable and livable spaces with a few belongings from home does not make it home for residents. The idea of home may bring with it some coercive elements as well. For instance, if the space is considered home, then assumptions of a home may be activated, and residents may be compelled to meet some expectations.

Chamberlain, Weeks, and Keefe (2017) note that in the Maritime provinces, new design models emerged from a culture-change movement that aimed, among other things, to install a physical design based on a resident-centered care approach. The influence of the culture-change movement can be observed in the architectural designs of neighborhood and cottage-style units with private resident rooms and central kitchens (Chamberlain, Weeks, and Keefe, 2017; Keefe et al., 2017). While homelike designs were juxtaposed with hospital-like designs, there is no focus on inclusivity or on the culture of the Black, Indigenous, or People of Color (BIPOC) communities, as residents or as staff.

In this section, I review photographs that provide a snapshot of everyday life in long-term care homes, to consider the degree to which these environments include and/or exclude immigrant racialized realities. I also consider what the photographs evoke, in terms of touch, smell, taste, sounds, and feelings. I consider photographs that include the food, physical spaces, and resident displays.

**Food**

In our research it was clear that meals are the highlight and main event of most days in a long-term care home. In addition to photographing the food, team members tasted all textures of food served
in the home, talked with residents and staff about the food and went into the kitchens to see food prepared and stored. In one field photograph from an Ontario long-term care home, a quasi-breakfast and sweets bar in a volunteer-run café that served both residents and visitors stood out. The wooden “bar” was made up of eight compartments. Four compartments held items for sale, including handcrafted winter toques and scarves and colouring books, while the other compartments were filled with breakfast groceries and sweet snacks for sale. Particularly interesting were the breakfast items and candies displayed in the compartments that reflected the particular tastes of mainly white North Americans, including oatmeal and cornflakes, Mars, Smarties, and M&Ms. A photo of the kitchen storage from the other Ontario home shows the spices, juice, canned sauces, cabbages, potatoes, and other foodstuffs used to make traditionally European meals. Across research sites, our documentation revealed typical menus that include milk, apple juice, salad, applesauce, BBQ-flavoured meat, mashed potato and gravy, cabbage, meat loaf, boiled potato and gravy, mixed vegetables, chocolate pudding with cream or diced peaches and pears, and coffee/tea. Long-term care home food, restricted by both funding limitations and understanding of what most residents will accept, is typically a bland version of a Euro-North American diet.

The photographs demonstrate the cultural specificity of these meals and how different they are from the meals favoured by many immigrant households. For instance, many immigrant foods are spicy and include foodstuffs like rice, yams, and other vegetables not found on long-term care home menus. Typical long-term care foods taste and smell different from what most immigrant care workers are used to and, together with other factors, communicate and reinforce a sense of otherness within the long-term care environment, especially for immigrant residents and the health care aides involved in feeding residents. The smells, sights and tastes of daily meals indicate that
these long-term care homes are for white settlers who accept this diet as normal, if not delicious. They are not for others. This is particularly relevant because mealtimes are social events and not connecting to the food may have implications for social relations in facilities for racialized and immigrant care workers.

**Physical space**

The photographic record of long-term care homes’ physical spaces was also imbued with the dominant cultural norms of white settler populations in Canada. This has crucial implications for those who live and work in those spaces (Braedley and Martel, 2015), and have a latent function of making a place welcoming to some, as they exude the values, ideas, and ideals of those who created them (Barken and Lowndes, 2018). In long-term care homes, physical spaces are highly controlled and regulated, yet they include elements that give a sense of the goals, aspirations, and expectations of individual facilities.

In one photo, a gas fireplace with books and comfy chairs forms a cozy proto-typical Canadian scene that includes a plastic model windmill, capturing a piece of the local context. This space was not used by residents, staff and visitors during our weeklong visit, giving an impression of a stage, rather than a setting to foster meaningful engagement among residents, families, and care workers. Other photos across sites show walls in mostly pale pastel colours, with bland landscape artwork that only occasionally reflected the location and settler history, with draperies, flooring, and upholstery in patterns and textures similar to those found in hospitals, doctor’s offices, and commercial settings.

At one of the research sites in Ontario, photographs on walls told a story about the local context and celebrated Canadian and North American history. The wall photographs stretched across the
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

hallway and were purposively designed to take visitors on a celebratory journey of 100 years of caring from 1910 to 2010. Brief historical summaries coupled with images of historical events were captured in those wall photos. The only indication or depiction of a racialized person was the listing of “Oprah’s Book Club” as part of the long-term care home resident events that took place between 1990 and 1999. The Book Club was a popular part of Oprah Winfrey’s talk show which spurred discussions of novels selected by Oprah. Although Oprah broke through mainstream media with her show and asserted the Black woman in the conscience of the American populace, the show fostered rather than deviated from White American norms (Driscoll, 2008).

While these photographs complement the facility’s character and celebrate its distinctiveness, they may be far removed from the experiences of immigrant and racialized care givers. It is pertinent to note that the history recounted and celebrated in the wall photographs did not celebrate diversity or include representation of BIPOC communities. Yet we know that racialized communities have been an integral part of Canada and the Canadian care economy for decades (Tungohan, 2013). This omission should not be taken for granted. According to Ortega (2013), photographs have a peculiar indexicality because they point to something that exists in the material world. Thus, this omission may point to the lack of recognition and acceptance of racialized care workers in that facility or the community at large. It is quite interesting that photos that span across a century, recognizing the experiences of care and care giving, would omit the contributions of racialized caregivers and omit any racialized residents as well.

Race, Racialization, and Culture

Racialization and racism are present in long-term care homes as in many social and institutional spaces in Canada despite the denial. As the work of Soltani (2017) demonstrates, many Canadians
are quick to dismiss the reality of racism in their social context. On most of our field research sites, there was an uncanny silence among managers and workers about racialized care workers and issues of race, culture, and racism. As a Black man, I found that as an attempt to neutralize, “unrace”, and sanitize the messiness of long-term care home space of racial elements instead of embracing them as part of their identity. Despite the pretense, racism and racial elements were observed on research sites. There were several cues and markers that pointed to racism in covert and overt ways.

Memory boxes were one of the pointers of how race was enacted within long-term care home space. Memory boxes are glass frames attached to the hallway beside resident rooms, next to the door panel. They are designed to provide a snapshot of a resident's life experiences and interests to visitors and care workers. In field photographs, I observed many cultural articles, artifacts, pictures of life events, and family members in memory boxes. In photographs taken of boxes associated with white settler residents in Ontario, there were artifacts of African origin, a chimpanzee, and other racially sensitive elements. For instance, in one of the two compartments of the memory box with African artifacts at the first Ontario care home, I observed dark wooden people, shirtless with clothes wrapped around their waist, standing on a platform. From the viewer's perspective, they appear as a family of four; a man, a woman, and two younger children. The other compartment of the memory box showed a multi-faced sculpted artifact with faces like those of Africans. Again, in another picture of a memory box, I observed a wooden chimpanzee, a wolf, a vase, and a few mini pots of Chinese origin from the second Ontario care home. Though the artifacts may display the travel history of the residents or portray something symbolic to them, chimpanzees have historically been used by racists to mock people of African origin. The colonial
histories, resonances, and symbols produce a sense of otherness, from my perspective, and one that could evoke discomforting feelings among Black immigrant care workers.

Another photograph from the second care home in Ontario was of a “get well soon” stuffed monkey doll. At this predominantly white facility where racialization and racism were almost unrecognized, this choice of doll could evoke an unwelcoming climate for some racialized care workers. Some racialized care workers have the experience of being called derogatory names of which monkey is part, and to see a monkey dangling on a resident’s door might be triggering for them. While the intention, in this case, maybe innocent, long-term care homes risk being culturally insensitive and racist if they maintain an unwillingness to understand racism.

Another photograph from the basement of the first care home in Ontario, includes two poignant pictures, I will call PA and PB to aid further explanation. PA is a board dedicated to one of World Vision’s initiatives for vulnerable children across the world. Quite revealing was the fact that in this white facility, where a peculiar European culture was celebrated and required for employment, only children of African descent were advertised on the board for support. While the initiative itself may be considered laudable, there were several unsettling images that the board portrayed.

The board details the life histories of children from South Sudan, Burundi, Haiti, and the Democratic Republic of Congo. These children were portrayed as vulnerable and from poor countries who needed donations from staff to rescue them from their deplorable living situations. This plays into the dynamic of the colonial imperialist powers, who were disguised as affable with an intention to liberate Africans (Nkomo and Al Ariss, 2014). I found it obnoxious that in a home where Black people were almost unqualified to work, donations were being collected for children of African descent. Yet the most damning of the images was PB, an image of a malnourished boy
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

from South Sudan, with the caption “famine declared in South Sudan, nearly 5 million people are suffering from hunger”.

A critical review of literature on the crisis in South Sudan and much of Africa reveals how colonial legacies continue to plague many countries in Africa. These legacies are exacerbated by current global economic systems that exploit African countries. Bad governance, conflict, and weak state institutions are crucial contributors to much of the exploitation and impoverishment of many African states. Such depictions perpetuate global imagery of Africa and African as savage, backward, and uncivilized and alternatively position white people as rescuers or deliverers, which is the same logic that fueled the annexation of African countries by Western imperial forces. According to Campbell (2006), this imagery of Black Africans as monstrous, inhuman, and primitive was popularized in medieval English pre-colonial discourse and was enlisted into colonialisit discourse but unfortunately continues till today.

As opined by Bohnsack (2010), pictures are powerful tools through which we constitute and construct our social realities. These pictures may shape the ideas care workers have about their racialized counterparts and their origins and consequently impact how they relate with them on the job. Yet, from the work of Armstrong, Armstrong, and Choiniere (2015), we know effective teamwork is an important aspect of the conditions of work and care in long-term care work. Beyond employee relations, the images could potentially influence the institutional culture to the detriment of racialized care workers.

Whiteness dominated these environments through the presence of Euro-North American markers, such as visual cues in pictures and artwork, furniture styles, colours and patterns, and smells of
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

food. Also, whiteness dominated through critical absences and through othering, such as in the image of African children in one of the care homes.

Promising Alternatives

Promising alternatives to the portrayal of racialized people and their cultures, as well as creative care models and activities that stimulate the sensibilities of seniors and/or trigger memory, were observed in some of our research sites.

In one of our field photographs from the first care home in Nova Scotia, I observed a wall photo of a racialized celebrity boxer. The boxer was celebrated across the province and was featured prominently in the home. This was the only facility that had a significant recognition of a racialized person. Noteworthy is the fact that this racialized boxer had to achieve legendary status to be recognized.

Another interesting photograph was of a poster in Punjabi on the administrative block of the second British Columbia long-term care home we visited. The photo was meant to educate seniors on healthy aging and elder abuse. The Punjabi poster was the only poster in a foreign language I saw in the field. Likely it was targeted toward the community of Punjabi speakers in the locality. The mere sight of it was a glimpse of hope and an indication of some form of reception towards diversity in rural and small-town Canadian long-term care homes.

Whiteness and Space: Unpacking Meaning

Spatial theorists point out that white ideologies are inscribed on spaces through their design and architecture (Leitner, 2012). The design of space tells us about who is welcomed and who is not. Through the organization of space, white ideologies, values, and culture are given permanence.
The relationship between space and white ideologies is bidirectional, as spaces reproduce the same ideologies from which they are built or organized. The role space plays in the production, reproduction, and contestation of whiteness has been documented by Frankenberg (1997) and Bonnett (2002). These authors theorize the relevance of whiteness and space to the process of othering and inscribing racial identities onto people. As the analysis of photographs taken as field notes in this study demonstrates, racialized people and the value they bring to the long-term care space was almost always overlooked.

The social and material design of spaces is inextricably linked to values, cultures, and ideologies. When we enter spaces, the way furniture is positioned, the writings on walls, the pictures, the smell, and the texture, communicate to us who it was designed for. The walls, designs, contours, lightning, and the organization of space communicate acceptance or rejection to people who enter it.

In long-term care homes, several ideas go into the organization of the space. Prominent among these are ideas about “home” or “home-likeness”, care models, and provincial regulations. When we begin to unpack the question, “home for whom?” we can trace clear linkages to gendered labour involved in maintaining space (Braedley et al., 2018). Whether in private homes or in institutional settings, women and increasingly racialized women continue to perform the labour required to preserve space as mothers, family members, friends, domestic care workers, and more. Long-term care homes are mainly designed for residents, although depending on the care home, some considerations might be made for workers in general. These limited considerations for workers do not take into account the peculiarities racialized care workers bring to the workplace because they
are more peripheral than centered. Simply put, long-term care homes were not designed with racialized care workers in mind.

The conundrum of invisibility and hypervisibility is evident when we bring to attention immigrant care workers in long-term care homes. Though they may encounter long-term care homes as alien to their experiences, values, and cultures, they are hypervisible because of the difference they present. Ahmed (2007) posits that when non-white bodies inhabit white spaces, they ‘stand out’ in invisibility because the space is white, and they ‘stand apart’ because they are hypervisible (p.159).

In this study, immigrant care workers in Nova Scotia became hypervisible under the scrutiny and surveillance of family members of residents and white co-workers because of existing tensions around occupational mobility. These racialized immigrant care workers had the audacity to question the status quo by moving from the health care aide level to the registered practical nurse level. Similarly, Leitner (2012) found that in small towns in America, successful immigrants became targets of projected grievances and were met with feelings of annoyance and fear because of their differences.

In Leitner’s (2012) account, cultural, linguistic, and racial differences were sites of contestation that were constantly negotiated. This finding is corroborated by Ahmed (2007) as she states that “the moments when the body appears ‘out of place’ are moments of political and personal trouble” (p.159). Immigrant care workers tend to handle the impact of whiteness more personally than politically because of the ways in which their immigration status might intersect with their race and class. Most of the immigrant racialized care workers are women, for whom work is pivotal to their immigration status, family, and survival. However, Anderson (2015) remains optimistic in his piece “The White Space,” where he claims that demographic changes and changes in
representation could potentially bring changes to how spaces are occupied and perceived. By extrapolation, racialized care workers could be perceived differently over time when their numbers rise in rural and small-town long-term care home spaces. Yet we know that representation does not always translate to power.

Unless racialized care workers and their allies mobilize to effect changes in the social organization of long-term care homes, little or no change will be realized. Anderson (2015) even recognizes that “the most easily tolerated Black person in the white space is often one who is ‘in his place’ - one who strives to fit in and does nothing or little to unsettle the prevailing status quo and implicit racial order. From the foregoing, it is apparent that the social organization of space invests meanings in the people that navigate them” (Ahmed, 2002). Racial identities are inscribed on many immigrant care workers based on their negotiations and navigation of long-term care homes.

**Concluding Thoughts**

From the foregoing, it can be established that white culture, values, and ideas are centered in long-term care homes in rural and small towns. As this chapter has demonstrated, the design of long-term care homes, the food served, and the organization of physical space creates an ambience and aura that perpetuate the detachment of immigrant care workers from white environments in long-term care homes. The subtle cues coded in images, smell, food, and other culturally distinct symbols demonstrate that rural and small-town long-term care homes were created for white settler Canadians. A few noteworthy promising practices were also identified and worth highlighting. While these pertinent attributes of care homes are crucial components of their character and context, care homes must evolve to incorporate some culturally diverse elements if they seek to be inclusive.
Chapter 6: Real People, Real Stories, Real Lives Stories

What does it feel like to be a racialized immigrant worker in long-term care homes in small Canadian towns and rural areas?

The stories in this chapter address this question and are used as tools to unearth deeper meanings about lived experiences and research contexts (Chivers and Newman-Stille, 2018). As I share stories developed from my interviews and observations, my goal is to give voice to these workers’ lived experiences. In this chapter, I argue that immigrant care workers' life experiences of racialized care workers extend beyond long-term care work, although long-term care work is implicated in their everyday life realities. Here I attempt to humanize them within the labour processes in long-term care homes, showing the trajectory of their lives before and after entering Canada, their family responsibilities, immigration struggles, and class positions. I also insert my own experiences as I identify with them in the struggle to enter and live in Canada in the face of persistent discrimination.

The stories are evocative and tap into the affective realm to reveal what it feels like to be a racialized care worker in long-term care homes. In this research, I introduce these workers as people who have histories and families and happen to work in long-term care homes rather than depict them as only immigrant racialized workers in this discussion.

These stories also include some autoethnographic material. I tell about my encounters in each home as I navigated it as a Black feminist political economist with social work training. Being Black is a permanent marker that shaped the social relations I was involved in during the study. I position myself here deliberately because my identity, perceived and real, impacted the
conversations that grounded the stories. The present, the absent, the revealed, and the occluded, as I recount them, must be understood through a prism of my experiences of race and racism as a Black immigrant man from Ghana, West Africa, with a commitment to social justice.

Further, I tell these stories to work out the degree to which my social location is similar to and different from the workers in this study and how it may influence my analysis. My analysis in this chapter is anchored by my theoretical frameworks. I particularly draw on the work of Yancy (2008, 2012, 2015), as noted in my methodology. Also, I begin each story by providing some context revealing the moment within which the conversation occurred or the general context of the facility. I use pseudonyms in place of care workers' names to ensure confidentiality.

**Making Choices: Juggling the Dimensions of Precarity**

It was afternoon, and after completing several hours of observations, I met a racialized care aide hurrying down the hallway to have her lunch. I approached her and politely asked for an interview. After establishing rapport, I turned on a recorder, and the battery died in a couple of minutes. Unfazed by that letdown, we proceeded to have a chat, which I recounted in my field notes. Her story reveals the many dimensions that make long-term care work precarious for all workers and additionally precarious for workers in the lowest positions in the professional and occupational hierarchies. Arguably, direct care workers, known as PSWs or care aides, are at the lowest end of these hierarchies. Within this occupation, casual and part-time workers are the lowest. It is in these jobs that racialized immigrant workers are clustered in long-term care homes across Canada. These jobs are precarious in three main ways for all workers who hold them. First, they are jobs characterized by high levels of physical and psychological strain, violence, and high injury rates (Braedley et al., 2018; Lightman, 2021). Second, they are precarious because wage rates are
relatively low, although significantly higher than minimum wage rates. At these wages, workers live paycheque to paycheque and will barely cover housing, food, transportation, and other necessities, if at all (Armstrong et al., 2020). Third, part-time and casual work is often work with few to no health care benefits, pension plans, or stable, reliable income. In work characterized by high rates of injury and job strain, these benefits provide important social security, and their absence produces a third level of precarity. Finally, some part-time and all casual staff are not union members, are not covered by collective agreements, and do not have recourse to labour protections associated with union memberships, from benefits to grievance procedures.

Agwa is a middle-aged woman working as a care aide in Nova Scotia. She moved to the province with her husband when he found a job opportunity there. She worked casually on a part-time basis and preferred the flexibility part-time work provided compared to full-time employment. Over a couple of weeks prior to the interview, Agwa had worked more than full-time hours (80+), as she needed money urgently to support her family. At fifty years of age, Agwa described that her physical strength was waning, but she pushed herself to work as many hours as possible and tried to take some time off when she was overwhelmed. The flexibility part-time work offered allowed Agwa to deal with the physical strain from care work and balance work and home life.

Her workdays were intense and included getting residents ready in the morning for breakfast, feeding, toileting, helping with showers, watching residents, and chatting with them when they found the rare opportunity to do so. Agwa described a heavy workload at work with frequent short-staffed shifts. She explained that working short-staffed meant rushing to complete assigned care roles and sometimes feeling disembodied in the process of care. She felt she did not always have the capacity to provide the care she knew was necessary under the working conditions. There was
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

hardly any room to chat or talk to residents, and when unplanned events like falls or illness happened, every routine was thrown into disarray. Agwa cared deeply for residents, tried to memorize their individual routines, and did her best to provide the best possible care in the face of what she described as significant time pressures. However, that was difficult to do as a casual worker with inconsistent assigned tasks around the facility.

Like many other casual workers in long-term care homes across Canada, Agwa had no health care coverage (Armstrong et al., 2008). Her work was also strenuous and physically demanding. Though she was concerned by her lack of health care coverage, she was lucky to have some health care coverage from her husband’s job but no disability insurance or pension. She had increased the number of hours she worked recently because her family needed the funds.

Agwa’s story is telling because of the risks she took. With the physical strain, violence, and dangers associated with long-term care work, a single ailment could deplete all her savings or plunge her into debt. Like many racialized immigrant care workers in long-term care, Agwa worked under the most precarious conditions and was compelled to make these hard choices to earn enough money to care for herself and her family. Many racialized care workers become apprehensive towards any form of deduction because of the immediate financial implications it may have for family care and sustenance. For those in the most precarious employment situations, healthcare coverage fees, union dues, and other pertinent deductions may have serious implications.

When I raised further questions about her health care and disability coverage, I could see her posture change, shifts in her tone of voice, a grim facial expression, and a general demeanor change as though to communicate to me a sense of discomfort because I had hit a nerve. The class
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

implications of Agwa’s story and the many care workers in her position, working as casual workers in a casualized long-term care sector, are far-reaching.

Although the flexibility of part-time casual work is often presented as an advantage for older workers like Agwa, it is in the context of limited opportunities for full-time work that their socio-economic challenges compel them to work over full-time hours as casual workers to support their families. Also, short staffing in long-term care homes often leads to rushed and incomplete care, leaving care workers like Agwa feeling dissatisfied and disconnected from the people they care for. Part-time workers in long-term care homes, like Agwa, often lack healthcare coverage and other benefits, making them vulnerable to financial strain and uncertainty. Racialized immigrant care workers in long-term care homes face precarious employment situations and are compelled to work in difficult conditions to support themselves and their families. The class implications of Agwa's story are significant and highlight the need for better job security, safety, and benefits for care workers in long-term care homes.

Chilly Climate: “All I want is tolerance”

While Agwa’s story reveals many of the material dimensions of long-term care work precarity, Meera’s story depicts another dimension, revealing how covert racism and xenophobia operate to maintain the whiteness of long-term care homes through social interactions and exclusions. While Agwa’s story foregrounds dimensions of gender and class, Meera’s story foregrounds dimensions of immigration status, culture, language, and race.

This is another Nova Scotia story, in a province that has become a destination for new immigrants, including racialized healthcare workers, because of the Atlantic Immigration Pilot Program (AIPP), now the Atlantic Immigration Program (AIP), and other strategic programs aimed at
recruiting immigrants with specific skills. The AIPP was created in 2017 to address the labour market needs of the Atlantic province in Canada, which has historically faced demographic challenges and labour shortages. The AIPP offers a pathway to permanent residency for skilled immigrants who have a job offer from an employer in one of the four Atlantic provinces: New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island (Government of Canada, 2022). As indicated earlier in this dissertation, a significant number of healthcare workers in care homes in Nova Scotia had moved from Ontario to pursue a much clearer path to permanent residency in Nova Scotia (Nourpanah, 2019 a, b). From my conversations with racialized care workers, it became apparent immigrant care workers from East India had a defined path to permanent residency from their home country.

This path included the work of organizations from their home country who assisted them in applying to study in Canadian colleges, mainly Conestoga College in Ontario, after which they could work as personal support workers or health care aides while they certify their nursing degrees from their home country (Nourpanah, 2019b). In order to work as a registered nurse or registered practical nurse, healthcare workers must meet the requirements for registration with the College of Nurses of Ontario, which include completing a recognized nursing program and passing the Canadian nursing registration examination, or Canadian practical nurse registration examination. While they pursue the certification of their foreign credentials, immigrant care workers apply for permanent residence through the AIP and eventually apply for Canadian citizenship.

At the care home, the occupational upward mobility of the racialized immigrant care workers had become a source of tension among workers. White coworkers at the care aide level were unhappy with the progress of immigrant care workers, especially when they had to take direction from their
former immigrant colleagues (who had worked with them previously at the health aide level). Being held at the bottom of the occupational hierarchy was not only sanctioned in discriminatory Canadian policies but also in social relations among workers. This is the context within which I share the story below.

Meera was a registered practical nurse in her mid-30s. She had moved from East India to Canada after working for several years as a registered nurse. Meera entered Canada as a student with the aim of staying in Canada permanently. She studied for a couple of years at Ontario College and received a three-year postgraduate work permit after her studies. After graduating, she pursued the certification of her work credentials and permanent resident status in Canada concurrently. Meera moved to Nova Scotia after being advised by her friends to do so, given the fast pathway to permanent residence through the AIP. Fortunately, Meera’s prior experience in India as a registered nurse allowed her to work as a care aide. She continued to work until she passed her certification examinations and qualified to work as a registered practical nurse. She later obtained her permanent resident status as well.

Despite these successes, Meera expressed a sense of discomfort and tension at the care home where she worked. She explained that there were frequent complaints about her from family members and some of her white colleagues. Family members complained about her accent and insisted that residents could not hear her when she spoke. From time to time, she heard some of her white colleagues talking behind her back, and that made her feel very uneasy. Responding to a hypothetical question asked at the end of our interview; “if you had a magic wand and could change anything in long-term care in general or your care home in particular, what would it be?” Meera noted, “All I want is tolerance”. She explained she did not feel welcomed at the care home. She
wanted residents, management, and coworkers to tolerate their presence so that they could do their work in the most effective way possible. She explained that having to navigate this emotional burden added to the high-stress work environment, which was already heavy in terms of workload. She felt the emotional and psychological drain every day on the job and thought more acceptance from her colleagues and others would make a difference.

Meera’s desire for tolerance is poignant when juxtaposed with her role as a care worker in a long-term care home. She was tasked with the provision of care for residents, yet she did not feel comfortable doing so because of what she experienced as a built-up tension within the care home. By extension, she was expected to provide care in an uncaring environment. This is what Sandler (2005) posits as a chilly climate, an uneasy and unwelcoming feeling in the work environment, difficult to point to but enacted through social interactions, including being left out or excluded from conversations, receiving glances that seem hostile, or avoidance of eye contact. The uneasiness is seldom superficial and often the veneer of deeper unresolved impediments or issues. In Meera’s case, some of the complaints were undercurrents of the tensions and discomforts that resulted from the occupational mobility of the Indian care workers. This parallels Nkomo and Al Ariss’s (2014) exposition of white dominance in organizations. According to Nkomo and Al Ariss (2014), white dominance comes with implicit ideological and material benefits for those who label others as inferior through the practices of exclusion. White identity becomes a psychological wage for white workers to use to distinguish themselves from similarly situated racialized care workers (Lipsitz, 2006). The construction of white identity is juxtaposed with the inferiority of other racialized groups and becomes central to exclusionary practices (Nkomo and Al Ariss, 2014).
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

In this story, the progression of racialized immigrant care workers from care aide to a registered practical nurse role or registered nurse role was observed as an unnatural encroachment on white space, causing tension between racialized immigrant care workers and their white colleagues. This situation serves to deflect the oppression white care workers experienced as they focused more on their racialized counterparts rather than on the oppressive working conditions (Roediger, 1999) in long-term care homes. The import of this story also corroborates the work of Glenn (2010) on racialized gendered servitude and Duffy (2011) on the constellation of racialized workers in non-nurturant care doing the dirty work. Both authors point to the historical and systematic assembly of racialized care workers in the lowest care positions, doing the least desirable forms of care. By extension, this systemic othering of the racialized worker makes it unnatural for them to progress in the hierarchy of care labour in long-term care, causing protests from their colleagues.

White coworkers did not understand and/or accept that most of the Indian care workers had years of nursing experience from their home country prior to working in long-term care homes and were waiting to complete their certification in order to progress to the next level or rank of employment.

**Immigration, Loneliness, and Social Isolation: Long-term Care Work as a Place of Solace**

Long-term care work is not only hard, poorly compensated, and laden with inequity. It is also a source of belonging, especially for immigrants who have not been able to reunify with family members and who may be living in Canada without kinship networks or cultural communities. Manna’s story is, in some ways, a contradiction of Meera’s, but it also shows that racism and exclusion can intermingle with a sense of belonging and solace.

Manna is a healthcare aide in her mid-40s on Vancouver Island. Manna had worked as a travel nurse in the Middle East for over a decade before moving to Vancouver, Canada. She had lived in
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

the Middle East without her family and yearned for the opportunity to live with them while working. Manna had always felt conflicted about leaving her family for work overseas and regretted missing the milestones in her children’s lives. When a friend told her about the opportunity to move to Canada with her family, she was so excited and applied without hesitation. Being able to move to Canada together with her family presented an opportunity for stability in her family - something she had always wanted. Unfortunately, the strain of moving and settling in a new country caused a breakup in her marriage a couple of years after moving to Canada.

After her divorce, Manna provided for her children’s financial needs while they lived with her ex-partner. She lived on her own and visited her children whenever she could. She was very proud of the beautiful teenagers her girls were becoming and how smart they were in school. To curb loneliness, she spent most of her time at the long-term care home, reporting earlier than her start time and leaving later than her closing time. Manna explained that she found the workload heavy and the conditions of work difficult, especially when her team was working short, which was often the norm. Unlike her colleagues, however, her only real connections in the small community were those from work, so she would not leave immediately after work like everyone else. After work, she would stay a little longer on her unit, talking to residents and spending more time at the employee lunchroom to connect with some of her friends before leaving work. Manna strived to find joy in little things and remained grateful for the trajectory of her life. For Manna, seeing residents smile and thanking her after caring for them is one of the little joys that made her day.

As Manna shared this part of her story, I could see her eyes and head fall and hear pauses in her voice as though to communicate pain. Though she took breaks from time to time to see her kids, most of her time was spent in long-term care, either working or hanging out with coworkers and
residents. Although we discussed many aspects of her work, what stood out was her personal story. She shared a story about loss and a deep connection to the long-term care home and the people who lived and worked with her there, yet the perspectives and experiences of workers are seldom considered in the design and organization of long-term care spaces (Braedley and Martel, 2015).

Where they feature, they are considered auxiliary to quality of care rather than pivotal. With the immense focus on residents and allopathic care considerations, including medication, workers and their ideas are circumscribed to the periphery (Banerjee et al., 2015). For many racialized workers, long-term care homes are places and spaces where they spend most of their time working long hours and picking up shifts in the face of acute staff shortages (Syed, 2020). Ironically, care workers in long-term care homes feature prominently in media sensationalism of staff to resident violence, in scrupulous regulations, and under hyper surveillance and scrutiny from concerned family members.

**Immigrants as Natural Caregivers? “Just like back home”**

Agila’s story reveals a further contradiction affecting immigrant racialized care workers. In this case, immigrant care workers from the Philippines, the Caribbean, and Africa are often positioned as more cut out for care because of the cultural traditions involving care for older people in their countries of origin. Adding to tropes of women’s “natural” caregiving abilities, racialized immigrant care workers mobilize these stories in their own self-understanding.

I met Agila, a Filipino healthcare aide in her mid-40s, at a Vancouver Island long-term care home. She worked on the afternoon shift full-time and had been working at her care home for several years. Agila had an affable personality and was quite a popular care aide in her long-term care home. She enjoyed caring for residents and always tried to go over and beyond to connect with
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

them personally. For her, that was a pertinent part of care work. She communicated her affection for residents with a warm touch, smiles, and attentive listening to their needs and preferences. During my interview with Agila, one of the residents whom she knew came by, fondly touched her shoulder, and smiled.

She reciprocated with a smile, then told me that Filipino women are “natural caregivers”. Agila explained, “I care for them like they are my parents, just like back home. The only difference is that back home, they are in our homes, not in facilities like this”. I was quite intrigued by her comment as I considered it within the context of the works of Nicole Yeates (2009a), Helma Lutz (2011), and Rhacel Salazar Parreñas (2005) who explore the domestic service sector and tease out the ways in which such romanticized caring discourses and clichés were used to exploit home care workers. These authors posit that Filipino Nanas were compelled to care under the most precarious conditions by capitalist organizations that commodified and profited from home care. The domestic service sector is also stratified by “skin colour and cultural considerations, with employers expressing a preference for those with (assumed or real) behavioural, cultural, linguistic or religious traits thought to bear on the quality of the service provided” (Yeates, 2009a, p. 222).

Although the contexts differ greatly, I began to draw parallels because long-term care work, like home care, is low waged, feminized, and racialized. Authors like Duffy (2011) also draw parallels between the feminization and racialization of care labour and the low wages of care workers. Lessons from feminist activists teach us that the construction of care work as natural to women is fundamental to the value attached to it (Glenn, 2010). Here feminization, country of origin, and racialization are at play, and the double jeopardy of their intersection and the compounding effects they bring to bear on the lives of racialized care workers cannot be overlooked.
The manipulative narratives that position racialized immigrant care workers as substitutes who fill the gap created by the care deficit and as better caregivers than white women who are understood as leaving unpaid care roles to pursue paid work make them susceptible to exploitation. These manipulative narratives are used by capitalist agencies that recruit and exploit the labour of racialized immigrant care workers.

**Consciously Unconscious: A Tale of the White Gaze**

This story emerged from my experience with a registered practical nurse in an Ontario care home. As part of our research process, the research team is adept at blending into the long-term care home’s environment, quietly making observations, and engaging research participants in formal and informal conversations. On this day, after about 30 minutes of observations, I chanced on an opportunity to shadow a white registered practical nurse. I introduced myself as a researcher on the study, which had already been well-advertised at the care home and indicated on a large badge I wore on my chest and sought her consent to ask a few questions while I shadowed her. She agreed, and so I walked with her as she gave medications to residents.

I observed that she knew the residents well and administered their medications in common areas and in residents’ rooms. As we began to chat and establish rapport, she asked questions about the research initially and quickly transitioned to questions about me, including my role on the team, where I was originally from, and how long I had been involved in the research. Afterward, she gave me a rigorous lecture on her role and its importance in long-term care, on medications and the conditions for which they are administered. For me, as a novice researcher in long-term care, it was useful information, but amid her elaborate lecture, I sensed an intense performative pressure, as though she wanted to prove to me that this was her forte. Aligning the verbal and nonverbal
cues and tone of voice, I felt uneasy and spoken to, not spoken with. The avalanche of information spewed without recourse to me, the listener, leaving me somewhat perplexed and thinking how the conversation might have been different if I presented differently.

In reflecting on this experience, both with the team and alone, I reviewed the feeling of being interrogated and talked down to and the resultant feeling of being out of place. My junior status on the team, combined with my international student status, Blackness, and masculinity, appeared to present a threat in that the white worker had to assert and demonstrate her expertise and put me in my place in some way, a place that was inferior to her own. It was an operation of white dominance in that without ever referring to race, immigration, or gender, this white care worker’s lecture racialized my Black immigrant body as not belonging and being alien to that social space (Ahmed, 2002). According to Ahmed (2002), such encounters demonstrate how white people position themselves as belonging and simultaneously withdraw from Black people’s presence in a social space (p. 59). This Black person in this space does not only look different but must be different. The nurse’s questions to me focused on my alterity. Her subsequent talk asserted her dominance, either consciously or unconsciously. Further, through her intense performative lecture, she sought to legitimize her perceived superiority and why she felt she belonged in that space. Though there is the possibility that I might have misread these verbal and non-verbal cues, the fact that her questions and comments left me feeling out of place is telling. This experience left me with an embodied empathetic understanding of the experiences recounted by immigrant care workers who labour in these workplaces without the privileges I enjoyed as a researcher.

Similarly, Yancy (2008) recounted an experience with a math teacher who sought to return him to a stereotypical position when he shared his “lofty” aspiration of becoming a pilot. According to
Yancy (2008), the white math teacher said he should become a carpenter or bricklayer, which was more appropriate for him as a Black teenager. As Yancy (2008) poignantly notes, “he returned me to me as a fixed entity, a “niggerized” Black body whose epidermal logic had already foreclosed the possibility of being anything other than what befitted its lowly station” (p. 68).

Extrapolating from Yancy’s (2008) experience, there is an implicit connotation behind intrusive interrogative questions asked by some white people. Questions about the legitimacy of Black people in social spaces perceived or designated as white are embedded in preconceived notions that Black people do not belong to such spaces. This creates a constant uphill burden of proof for many racialized people as they navigate social spaces. The next chapter sheds light on whiteness and white dominance in institutional environments.

These stories illustrate the operation and some of the effects of the inequitable relations of gender, race, immigration status, and class that shape the experiences of immigrant care workers. They show some of the ways that white dominance shows up in long-term care homes, including precarity, chilly climate, and covert and overt racism. But they also show that long-term care homes can and do offer these workers meaning, purpose, and a sense of belonging, even at the same time as they are “othered”. The immigrant care workers in these stories had different life trajectories, worked, and lived in different contexts. Yet, their experiences in relation to the conditions of work had more similarities than differences. At some points in my analysis, transcripts read identically or like a continuous script. As these stories have shown, immigrant, racialized care workers are compassionate people with dreams and aspirations who work to support their families. What is telling in each account is the poor conditions of work care workers navigate in long-term care homes. Violence, time pressures, inadequate staffing levels, and racism are
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

normalized, which makes the process of caregiving taxing. It is also pertinent to note that these racialized immigrant care workers demonstrated resilience and agency as they forged paths ahead in the face of adversity. As I sat with the interview transcripts, the stories I read jumped off the pages in ways that allowed for a creative spin that I share below as a poem.

**Immigrant Caregivers, Different Voices, One Story**

We come from many journeys, yet our story is cut from the same cloth
Hear me now and see the pattern in the puzzle
Across many oceans, I labour for me, for them, and our future
In a land of many cultures, I insert myself to care
I meet many people on similar journeys, yet mine is rare
Dusting the dirt off my feet now, I giggle at my pink shoes
This is hard work but better than where I came from
A little here, a little there, I will press on
I get hit, I hear unpleasant words - when you’re hurt, it hurts
I want to be part of this land
And this is how I know how
I hear you call me a foreigner in disgust
And I laugh, truly we all are, so those mean words do not bother me
Well, it does, but I focus on my family
The new home I have with my son and wife - they’re my drive

I differ in how I enjoy the freedom of being everywhere and nowhere
You need to understand my journey before your prejudice takes the lead
I entered a “home” when I came here, and I broke free after a long while
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Then I served on a line for a decade and then broke free again with my partner’s clutch

Now I desire more, so I’m freely bound in labour

To earn more and rest when I can

I know my residents, but sometimes I forget; that’s a lot to keep in mind

I want to earn more, but my uttermost desire is that one day when my body tires

I can have a clutch for myself - a line I can call my own

I value respect and dignity

I treat you as family and expect the same

I drive a long distance to this place of labour, I call home

I have been through many struggles to be part of this land

Yet all I hear is validate! Validate! Validate! - what’s in your hand?

I have parted with thousands in hopes of a better tomorrow

Where I can labour at a level I desire, and the journey continues

When it’s tough, I fall on my partner and cousin, who stand by me

It’s hard work and emotionally unnerving

Sometimes I just want to pause, sit, and chat because it helps me care better

That’s not usually possible

So, wand me this magic that I make create a more equitable workplace

Devoid of domination and ripe with equity

Better pay and fair conditions of work

Enough comrades on the field

Enough time to enjoy the fleeting thoughts

And to take advantage of those moments
For truly, we all share this human experience – life.

**Concluding Thoughts**

In this chapter, stories were developed from transcripts and interview notes, reflecting themes that emerged across sites and interviews. The stories were developed as instruments to unearth insights into lived experiences of immigrant care workers and their contexts. Through the sharing of stories derived from interviews and observations, my primary objective is to amplify the voices of immigrant care workers, offering a platform for their unique lived experiences. In the chapter, I contend that the life journeys of racialized care workers extend beyond their roles in long-term care, although it is undeniable that their experiences at work significantly impact their day-to-day realities. Here, my aim is to humanize them within the labour dynamics of long-term care homes, tracing the trajectory of their lives both before and after their arrival in Canada, and shedding light on their familial responsibilities, immigration challenges, and social class positions. Furthermore, I intertwine my own encounters and experiences as I empathize with their struggle to enter and settle in Canada while navigating discrimination.
Chapter 7: It’s a Set Up! The Experiences of Racialized Immigrant Care Workers in Long-term Care

In this chapter, I argue that long-term care work, and especially front-line care aide work, is a set-up for racialized immigrants to Canada. Due to a serious labour shortage and relatively minimal educational requirements, long-term care work has become an established, even marketed, path to permanent residency for some immigrants. It is also employment available to healthcare workers with unaccepted international nursing and other healthcare professional credentials, allowing them to gain Canadian experience as they work toward achieving entry into their professions. At the same time, the sector’s structural limitations across the three jurisdictions considered in this dissertation, including funding, legislation and regulation, and policy, produce working conditions that have a deleterious impact on racialized immigrant care workers. Structural limitations are compounded by increasing for-profit involvement in publicly funded care. Rather than retaining and rewarding these much-needed workers, the poor conditions of work adversely impact their health, undervalue their labour, and exploit their often precarious financial, citizenship, and family status. At the same time, many of these workers, longing for a sense of meaning, belonging, and purpose, acquire psychological wages at work in ways that retail, manufacturing, and other kinds of work available to them cannot provide. This contradiction is at the heart of the set-up, providing relational rewards in a context with brutal working conditions and low wages.

Drawing on interviews and observations, I parse out the dimensions of this set up. First, I outline further how precarity shows up in long-term care work. Following that, I explore how violence, covert racism, culture shock, and arduous certification processes exacerbate the already deplorable conditions of work for racialized immigrant care workers. Finally, I explore the agency of
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

racialized immigrant care workers by analyzing pertinent aspects of their coping and resistance under the oppressive conditions of work in long-term care homes. Here, I discuss how teamwork, compassion for residents, opportunities for immigration, family support, building a community of racialized workers, and humour, allow racialized immigrant care workers to cope and resist exploitative conditions in care homes.

Dimensions of the Set-up: Precarious Life Conditions, Precarious Work

Long-term care work is typically precarious work for all of its labour force, as discussed in chapter 3. It is also work that exploits the existential precarity often embodied by racialized immigrants to Canada. With debts to pay related to the costs of immigration or education, with families who expect and need remittances sent regularly, with temporary migration status and hope for permanent resident status, with aspirations of professional jobs and financial security, racialized immigrants are looking for answers to solve complex, urgent issues in their lives. Further, for some racialized immigrants, coming to Canada is the first time that they experience themselves as racialized in a white-dominated society. This combination of material conditions, laden with hopes and fears, creates uncertainty and insecurity that saturates the lives of many racialized immigrants.

It is not surprising, then, that many racialized immigrants are pulled into long-term care aide work. With the relatively minimal educational requirements and pay that is higher than typical retail and service jobs, those who work in long-term care homes are working hard to improve their financial situation. Among the participants in this study are racialized immigrant care workers who worked full-time shifts and picked up extra shifts regularly, which were always available because of the acute shortages of workers in the sector. Others worked part-time and casual shifts, which allowed them to work across several care homes. Full-time jobs were scarce and remuneration low, so
picking extra shifts was a way to increase earnings. Some care aides did clarify, however, that the pay they received was better than their previous live-in caregiver jobs. This underscores the precarious occupations in which many racialized immigrants are employed, and relative precarity across occupational categories and settings (Estabrooks et al., 2020).

The acute shortage in the long-term care sector is explained succinctly in the experience of the licensed practical nurse below. Though they worked full-time on a twelve-hour shift rotation, they explained that they picked up extra shifts regularly in their pay period. A Nova Scotia LPN said, “… if somebody called in sick or they are short-staffed, they always call. They almost call me every day”. As implied in the second part of their statement, working short-staffed is a regular occurrence; thus, the long-term care home reached out to care workers constantly to have them fill in. In the context of these acute shortages, immigrant racialized care workers are more likely to pick up extra shifts because of their social location, including low family income and the burden of sending remittances.

Comments from a racialized health care aide from BC who was casually employed but worked full-time hours clearly expatiate this idea. “… So the reason why I’m working is because, you know, we need the money to support them (my family), yes… We’re nine in the family, but I’m the one”. This racialized care worker gave an account of their humble upbringing on a farm in the Philippines and their appreciation of the job they have and how it allowed them to support their parents and family. Reflecting on their background, this racialized care worker explained that the work involved in caring for residents was difficult but better than working on the farm without shoes. Also, she put in as much time as her body could handle because of the financial obligations
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

she had to fulfill in caring for her nuclear and extended families in Canada and the Philippines, respectively.

Again, immigrant care workers are likely to labour precariously because of the many responsibilities they take on both in and outside Canada. This aspect of their social location leaves them scrounging for extra shifts to get by. The finding is consistent with the findings of Syed (2021), who studied remittance flows from precariously employed immigrant long-term care workers in Toronto. The question that remains unresolved is whether they would work with the same level of intensity, going over and above, if the compensation for their labour was better. However, there is no denying that their subjugated position in the care economy allows for the exploitation of their labour under poor working conditions.

These findings are also consistent with the findings of Shutes and Chiatti (2012), who utilized a data set from the United Kingdom to analyze the unfavourable positions of racialized care workers in the care economy. According to Shutes and Chiatti (2012), migrant care workers were relied on by managers to work overtime and work less favourable shifts to address staff shortages because of the challenge of recruiting and retaining care workers in the long-term care sector. Migrant workers are often willing to labour under poor conditions of work because of several factors, including family income (Shutes and Chiatti, 2012; Novek, 2013).

Finally, as indicated above, due to the casualization of care in the long-term care sector, most racialized immigrant care workers laboured precariously in casual or part-time shifts with few or no benefits, yet with full-time hours and beyond.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

The circumstances of a health care aide from Nova Scotia clearly illustrates how racialized immigrant care workers are rendered precarious in this labour relation. In this case, the worker was a part-time employee but routinely worked full-time hours but without the benefits and protections provided to those workers with full-time permanent status. She explained, “I’m part-time, but I’m doing regular, more than 80 hours” and signaled that this was the normal trend at her care home. Pertinent to note is that she did not have control over the extra shifts she worked. It could be on a different rotation, at a different location in the care home, and on a different shift. This adds to the existing precarity and deplorable conditions of work. On these short-staffed shifts, there is the tendency to be short-staffed even after racialized care workers sign-up to support the facility. From the perspective of the employer, this work arrangement is both cheaper and more flexible than hiring more full-time workers. Canadian-born workers also take these jobs, but increasingly, it is newly immigrant racialized workers who accept this work as a foothold into “Canadian experience” necessary to permanent residency and who get stuck in these occupational categories and positions.

The pertinent question here is whether the immigrant care worker would have maintained work in these number of long-term care homes if the remuneration was better. However, to assess the level of precarity only in terms of remuneration alone would lead to an underestimation, as racialized immigrant care workers continue to navigate other tumultuous conditions of work, worsened by the casualization of the long-term care sector and the acute shortages of workers.

Practically, workers on multiple shifts across multiple sites are less likely to keep a robust memory of the residents they take care of. Though this is not a definite indication of the likelihood of violence against care workers, in combination with other poor conditions of work, it becomes a
The words of a casual care aide below describe what it means to work on casual shifts across multiple sites.

Yeah, you ask question, especially, I’m casual, right. I’m not here every day, so I don’t know the residents very well. If I know but, sometimes I forget because I’m dealing with three nursing homes. Soon it will be four nursing homes because I’m going to different nursing homes too. - British Columbia, health care aide

This comment clearly details what it means to be working in multiple homes as a casual worker. Care aides who provide direct care to residents may forget the needs and preferences of some residents if they are working across multiple facilities. Yet, because of the low remuneration in long-term care homes, many of these care workers are compelled to take as many shifts as possible, wherever possible, to meet their financial needs. For residents receiving intimate care from different care aides on different days without consistency, the care experience could be very unsettling and even disrupting for residents with dementia (Caspar, Brassolotto, and Cook, 2021). These working conditions make violence more prevalent in long-term care homes. On these shifts, there is the likelihood that the most vulnerable care workers or care workers in the lowest occupational levels would be susceptible to acts of violence (Syed, 2021). The next section explores this idea further.

The normalization of short-staffing levels across facilities in the study exacerbates the poor conditions of work for all workers, especially racialized care workers who are more likely to be on short-staffed shifts as casuals or replacement staff. Care workers on these shifts are less likely to know the residents and all their preferences, moods, behaviours, and tacit communication patterns. Ponder, Longhurst and McGregor (2020) assert that the reliance on casual care workers
to fill in care gaps could potentially impact workflow as staff may not be familiar with their colleagues and residents.

**Violence**

Authors who document the conditions of work in long-term care homes have indicated that violence happens during crunch time when there is a shortage of staff (Banerjee et al., 2012; Daly et al., 2011; Braedley et al., 2018). Violence is often a response to poor conditions of work but is framed in terms of residents’ responses to the care process, with reforms focusing mainly on training than on structural challenges (Banerjee et al., 2012; Syed, 2016). The blame game is evident, and workers are the prime suspects. Working conditions such as insufficient time for care, heavy workload, lack of autonomy, task-oriented work organization, strict division of labour, and understaffing are largely ignored in policy changes (Banerjee, 2012; Syed et al., 2016). Work-related violence typically happens during the performance of intimate care, like bathing, dressing, and toileting (Banerjee et al., 2012).

Workers are bitten, hit, and hurt while they assist residents with intimate care on a daily basis. Resident behaviours or acts of violence are normalized in long-term care work, in ways that almost legitimize violence. Work-related violence normally goes unreported with the normalization of violence in long-term care homes. For instance, Banerjee et al. (2012) note that Canadian frontline care workers are six times more likely to experience violence on the job than their Scandinavian counterparts. These trends reflect the systemic challenges in long-term care homes that have adverse effects on workers’ psychological health and safety (Braedley et al., 2018).

In one of the seminal pieces on violence in Canadian long-term care homes by Banerjee et al. (2008), “Out of Control: Violence against Personal Support Workers in Long-Term Care”, four
core aspects of violence are identified; physical, verbal, sexual, and structural. These dimensions of violence have been corroborated by the works of several authors, including Banerjee et al. (2012), Daly et al. (2011), and Braedley et al. (2018). In this study, racialized care workers expressed that they experienced physical, verbal, and structural violence.

According to Banerjee et al. (2012), frequently documented physical violence in long-term care homes include: being hit, punched, poked, pushed, one’s hand being twisted, and hair pulled (p. 390). Physical violence was reported by research participants in this study as a common occurrence. A BC care aide responded to a question on aggressive behaviour, referring to locked units, which are restricted, code-accessible units for residents who are experiencing significant cognitive decline due to dementia and whose behaviour presents danger to others or themselves (Brophy, Keith, and Hurley, 2019). The care aide explained, “Yes, it’s normal. You can lock up unit, you can - and then the lock up still has aggressive people, right?... You got hit, you got hit. That’s it, you know. Incident report, that’s it, and then you give PRN if they do since need a PRN”. From the response, one can decipher that aggression or violence is routine in long-term care homes, especially in locked units. This acceptance of violence is not only in care worker discourses but is part of institutional practices that gloss over violent acts and treat them as part of the care process in facilities without appropriate interventions. Thus, this expression is not just about physical violence or aggression but, more broadly, about the structural violence that normalizes physical violence as part of the care experience in long-term care homes.

This normalization and sometimes trivialization of violence leaves many racialized care workers hurt, confused, and lacking support. Another healthcare aide from BC expressed how painful her experience of violence was and also how it was almost dismissed due to the resident’s brain injury.
There’s a lot. I have been punched here and everything, but, you know, like they say, brain injury, but, you know, if you get hurt, sometimes it hurts. My safety’s jus as important…And then I have been punched really hard and I did not – I can’t breathe from that, punch me here (pointing to her back) and I said to myself, what is that? And I have all the guard aids and everything on my hands. She’s behind me… I just got back from my injury that time. - British Columbia, health care aide

In the quote above, a health care aide from BC laments a terrifying, violent episode with a resident. She expressed the incredible pain she felt from that violent behaviour that caught her off guard. She could not immediately make sense of the painful sensation she felt, which aggravated a previous injury she was just recovering from. She was disappointed that the experience was just categorized as part of the resident’s cognitive impairment, and not much was done to support her. In our conversation, she insisted that it was not about her approach and surmised that it could have been related to the resident’s medication or outright discrimination. Another health care aide struggled to make sense of a violent episode where they were being chased by a resident and subsequently having their hands squeezed.

…[ The resident is] thinking I’m one of his family or something; his wife or something before. So, I was doing night shift. He doesn’t want me to stay there and he is chasing me to hit me. So, I had to leave from that wing… So, then a couple of times you know, depending they are not happy, they grab the hand and squeeze.
- British Columbia, health care aide

Left to rationalize the experience of being chased by a resident, the health care aide assumes that there is a mental condition that is influencing the resident’s perception of them. She believes the cognitive impairment configures her in his mind as his wife, thus the trigger to hit her. She also mentioned that her hand was squeezed a couple of times by the resident as a way of communication to demonstrate emotion, in this case, unhappiness. In what follows, the health care aide clarifies how squeezing of the hand could be used as communication for non-verbal residents.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Yeah, so depending, maybe some residents they won’t talk you know. They can’t tell what they want. You know, they’re angry they want to go bathroom too late. We don’t know what they want so sometimes they want to pretend they’re angry and so, they grab the hands too. - British Columbia, health care aide

As explained above, the health care aide describes how non-verbal residents could use the grabbing of the hand to express their anger, especially when they are incontinent and not attended to on time if they need to use the washroom. Unable to verbalize their needs, some residents grab care workers' hands to indicate their displeasure. This way of communication poses significant risks to care workers at the frontlines, though the health care aide, in this case, mentions that it has to do with pretense.

Although it is unclear if the pretense is meant to diminish the violence involved, the way it is casually described raises questions about the normalization of violence in long-term care homes. This is consistent with the findings of Banerjee et al. (2012), who noted that violence in long-term care homes goes unnoticed and unreported.

Another type of violence that racialized care workers mentioned is verbal violence. Verbal violence in long-term care homes may include sexist and racist comments targeted at workers (Braedley et al., 2018). Banerjee et al. (2012) in their study found that verbal violence accounted for one-third of all forms of violence experienced by care workers. Care workers reported being “criticized or told off” by residents or their relatives. Similarly, in this study care workers described experiencing being told to go back to their countries of origin, as well as other covert racist comments.

An immigrant LPN working in a long-term care home in Nova Scotia recounts being told to go back to her country. “Yeah, Indian or immigrants go back to your country”. In the care
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

environment, hearing that you do not belong and being told to go back to your country may be emotionally triggering, especially when immigrant care workers are seeking to support and offer help. It could be particularly discomforting as the study context was rural and small towns, and the neighbourhoods and social contexts are white. These comments can thus be very unsettling and evocative. Comments from a health care aide in British Columbia fleshes this out even further. She complained about name calling when she said, “…and then some residents calling me names and then she said go back to your country, you know. It hurts, but like they say, I’m here just to help you, but then, it’s very hurtful”.

The statement above reveals how some racialized care workers may process racist comments from residents. Here, the care worker recounts how hurtful it is to be on the receiving end of those comments when all they are seeking to do is to help residents through the day. Such comments may have implications for racialized care workers’ psychological health and safety (Braedley et al., 2018) and potentially deplete the emotional resources of care workers and impact patient care (Cottingham, Johnson, and Erickson, 2018).

Evans (2013) also found that in white institutions, racialized workers are indirectly tasked with an emotional “double shift” when they consistently navigate covert racism without support. While it is unclear if this experience was frequent, it is emotionally unsettling to work in an environment where you feel unwelcome. On some occasions, the racist comments are explicit, as revealed by an LPN in Nova Scotia, “Sometimes I do experience them calling me, you Indian bitch or something.” The male LPN from a care home in Nova Scotia described the experience of being called an inappropriate name while providing care for a resident. Though he explained that he did not take the comment personally, such racist comments only re-echo the existing disparities in
social relations and further the dominance of whiteness in long-term care homes. This experience also points to the structural dynamics at play, which allow racism to fester and create conditions under which residents may lash out their frustration at care workers.

Structural violence in long-term care homes refers to social and institutional processes that subtly but systematically impede workers’ ability to care for residents in the best way possible under humane conditions (Banerjee et al., 2012). In this study, structural violence was observed as the culmination of poor working conditions in long-term care homes. Structural violence was also fueled by the domination of whiteness in all facets of facilities, from intrinsic values to everyday organizational decisions that shaped them and served to ignore these poor working conditions and their consequences (Daly et al., 2011).

Structural violence creates conditions under which all forms of violence, including racism, thrive in long-term care homes. Workers describe a tense working environment where there are time pressures, heavy workloads, and a shortage of staff to complete the necessary care and ensure quality.

“…Sometimes we’re short staffed. That’s the big problem here…That’s my big problem here because if we’re full staff, then it’s okay, but if we don’t, like, you’re rushing yourself, and then it looks like you’re doing the care with one resident. You’re rushing back, and then one resident doesn’t want to be rushed. So it’s hard, so more of this is workload.”-British Columbia, health care aide

Rushing against time to meet the care needs of residents is almost a daily experience for many care workers in long-term care homes across Canada. Racialized care workers talked about how it is almost impossible to deliver quality care when they are stretched thin because there are not enough people on the job. The dismal looks on the faces of racialized care workers when they recounted
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

working under these deplorable conditions told a story not just of their experiences but of the systemic neglect of the long-term care sector as a whole. Probing further on the question of workload, a health care aide from BC revealed the following, “…Like hell. The workload here is, sometimes it’s heavy. Sometimes it’s okay. It depends. It’s unpredictable, like what I said, yes”. For this worker, the unpredictability of the work environment and the lack of control they experienced exacerbated the workload. Though she mentioned that it was okay sometimes, she explained that it was incredibly difficult when an unplanned adverse incident like a fall or illness happened during the workday.

Due to the frequent shortage of workers, any unplanned incident upsets the rhythm and flow of work, as there is no time allowance for such incidents. A personal support worker (PSW) in Ontario, which is the equivalent of a health care aide in other provinces, clearly explains the correlation between working short-staffed and quality of care when she mentioned, among others, that on days that they are short, they are unable to give baths. She said that “…if we are short, we have no time to give a bath”. She also explained that some of the residents might require two people to assist and hold them in lifts to bathe them, and that process may require more time. Also, for residents whose dementia has progressed significantly, their care needs become extra challenging to provide when there’s a shortage of staff. Explaining how difficult the work environment is, especially on the special floors or units where residents with dementia live, a personal support worker from Ontario recounts that the work is heavy, physical, and dangerous.

It’s heavy. It’s very heavy… Physical and sometimes - like both ways, right? It’s uh, sometimes dangerous too. Like special this floor… and you know, when you get used to it - you are not even scare anymore, you know, we are always careful, we know how to talk to people who is, like sometimes dangerous for us, and stay away from that and like, we have very good teamwork and when you have experience, you learn how to deal with people, right? If it’s dangerous or something. - Ontario, personal support worker
In the quote above, the racialized care worker notes that long-term care work is heavy, physically tasking, and dangerous. This comment corroborates the finding of Banerjee et al. (2008), Banerjee et al. (2012), and Armstrong, Armstrong, and Choinere (2015), who found that long-term care work in Canada is dangerous as workers experience physical violence frequently.

Further substantiating how onerous the workload was, an Ontario PSW reveals a practical example by recounting the recent turnover rates at their facility. According to the care worker, most prospective workers quit after the orientation to the job because of the workload. She explained that “…Uh, because, I told you, it’s heavy job. Not too many people want to do this job. We have—I don’t know how many people came for orientation and try to work—quit. Next day is not here, because it’s heavy. This narrative is quite intriguing as it has implications for the acute shortage of workers in long-term care homes. Structural violence serves as an impediment for prospective care workers as they decide against working in long-term care after experiencing poor working conditions.

The high turnover rates in the sector are directly correlated to structural violence that shapes the working conditions in long-term care homes (Brophy, Keith, and Hurley, 2019). For racialized care workers specifically, they become bandages and quick fixes to a system that is not working. The historical and continual denial of structural violence and systemic inequities in the long-term care sector makes it an undesirable sector to work in. Apart from the overt experiences of violence and racism, racialized care workers may experience subtle yet more pronounced forms of racism at workplaces.
Covert Racism

Covert racism happens discreetly under the public purview and is often taken for granted (Essed, 2002). Though it might sometimes be difficult to pinpoint racialized people and, more specifically, racialized care workers feel it and know that it exists. A distinctive feature of covert racism is that it is often normalized and not acted on or resolved, leaving racialized care workers to handle the psychological and emotional burden it brings by themselves (Essed, 2002; Lightman, 2022).

For the study context, that is, in rural and small towns, covert racism may be felt more strongly by racialized care workers as the spaces inside and outside the long-term facilities are incredibly white. White dominance is reified by the organization of the long-term care home space, activities, culture, and everyday connections and associations with residents, white colleagues, and management. At the end of the workday, many racialized care workers do not have the privilege of going home to familiar neighbourhoods or community lunch or dinner spots, local grocery places, or friends in their community. These external and internal conditions may not be directly related to care work but may affect how racialized workers feel within the work environment (Lightman, 2022; Sandler, 2005).

A racialized care worker from Nova Scotia describes what it feels like to work in a context that is isolating. When asked whether they experienced racism or any form of discrimination from their colleagues, he made the following short but very evocative comment; “Some of them like to work with their friends”. As a male working in a female-dominated sector, it can be challenging to develop collegial relationships, comradery, and friendships that make the work experience enjoyable and less burdensome. However, the feeling here, as captured succinctly in the words of this licensed practical nurse, is one of isolation. It is important to identify with colleagues in the
context of rural and small towns because of the opportunity it provides for immigrants to have white allies and people who can support them or speak on their behalf. Thus, to feel isolated from colleagues, who could possibly be the most relatable people at the workplace, is telling. From his comment, it is apparent that he does not consider himself friends with his colleagues and feels left out of the collegial experience other workers may share. The LPN explained that some of his colleagues had issues with immigrants, so management had tried to organize socialization events to encourage in-group bonding.

Another aspect of covert racism that was consistent in the interviews was the issue of language and accent. On most of the research sites, there were complaints about racialized workers' accents and how residents do not hear when they speak. While racialized care workers tried to mimic the Canadian accent as much as possible, they had little control over rumours and complaints about their accents. Though this issue varied from province to province, the impact on racialized care workers was apparent, and many of them tried to isolate the issue and focus on the delivery of care. A health care aide from BC normalized that experience as she went about her daily activities. She stated, “For me, that one is normal anyway. Wherever you go, right? Some people they don’t hear you, some people they don’t reply you. It’s human nature, you know”. She maintained that it is a normal experience as the experience goes beyond the care home. She adds that some people do not reply, which implicitly connotes the assumption that people hear her but choose not to respond. These complaints were also recognized in Nova Scotian facilities. The care worker, in this case, ignores the issue and focuses on the provision of care.
Culture Shock

Racialized care workers talked about experiencing culture shock when they started working in long-term care homes. The process surrounding death and dying and witnessing residents die without their families was heart-wrenching for them. Knowing that they left their families and parents in their home countries, they reflected on the distance and loss more deeply.

Most of the study participants described residents as their parents when they recounted their relationship with them. Perceiving residents as their parents, it was difficult for them to wrap their minds around the frequency of deaths and how some families were not directly involved in palliative care. A racialized registered nurse from Nova Scotia describes the experience of leaving her parents in her home country and working through the emotions of residents dying without their families.

'It was a shock when we first came here, like leaving parents in our home and not seeing them, not involved in any of their care. It was shocking… First the challenge was the people are dying and nobody is with them. It was very hard for us when we first started but now we know what is here. - Nova Scotia, registered nurse

The racialized care worker explained that it took some time to get used to the Canadian culture because death and funerals are perceived differently in their home country. Vicariously, she began to reflect on the experience and pondered on what it meant for her parents, whom she had left in her home country because she was absent and unable to provide care for them. In many cultures in the Global South, care for elderly parents is performed by children and grandchildren in a familial context, and death and funerals are community events that attract patronage from family, friends, and community members. Another LPN from Nova Scotia expressed astonishment at how some family members of residents were not invested in their death.
Yeah, even if something happens we call the families and tell them. Okay, that’s fine and sometimes if some residents are on palliative order or something and we call the families and they are going to die or they may die tonight or they’re that near. Okay, if died, okay, no need to call us. Send them back. Funeral arrangements are made. Okay, the funeral arrangements are made with… and you can call them and they’re not coming. And if they’re on vacation, they said okay, someone now, so they are going somewhere on vacation. Okay, anything happens, no need to call us. Send them back out. - Nova Scotia, licensed practical nurse

For this racialized care worker, residents’ family members were not adequately invested in the palliative process and the death and burial of residents. He found it to be particularly dismissive of dead residents and would have wanted to see some form of last respect given to dead residents in person. Again, he was shocked that family members of residents would not forgo pre-planned vacations to be with palliative or dead residents. The care worker was astonished by how disparate the culture of their home country was in relation to what they were experiencing. For them, death and dying were pertinent aspects of care.

**Certification Process**

Racialized care workers described an onerous certification process that compelled them to work at lower occupational levels than their international qualification would have allowed them to if they were accepted (Syed, 2020). The high cost of credential validation and the arduous processes involved deterred some racialized care workers from certifying their qualifications from their home country. As described by study participants, the process involved receiving validated documents from their home country to demonstrate their experience, fulfilling an English requirement, and taking examinations. The process took years to complete depending on racialized care workers' ability to fulfill all requirements or build new experience in Canada to gain eligibility to write their examinations. A racialized licensed practical nurse at the time of the interview described the process it took to gain their eligibility to take their certification exam.
It took so long to get that eligibility… They kept on asking for papers and there was no one back in India to send the papers to here, so it took a lot of time… I studied my nursing in India and worked in a central government hospital, but they need to send all the papers from them to get the papers… it is a big process. If we do have people back in India to send all of this it’s not a big deal. So I don’t have a bigger family and so I worked almost all places in India so they need to send papers from everywhere. - Ontario, licensed practical nurse

The racialized care worker explains a long process of document certification from their home country which was further complicated because they did not have an advocate who would follow up on their documents. Another issue of complexity in their experience was the number of places they had previously worked in their home country as each was required to provide proof of their experience.

An RPN from Ontario who was still in the process of validating their documents and writing the examinations for their RN license recounted their experience in the study. She explained that her nursing degree from her home country exempted her from taking a PSW program before working in the long-term care sector, so she worked as a PSW in the community while in school. At the time of the interview, she had gained her RPN license and was working on obtaining her RN license. However, she noted that she needed refresher courses because her three-year safe practice period for nursing had elapsed.

I’m still in process of becoming RN here, and in the meanwhile I went for RPN and got—as RPN license and meanwhile like, while getting lessons—I was working with seniors as a PSW in community... when we apply to College of Nurses of Ontario, they evaluate your degree, what you did back home—outside evaluation process takes a long time, sometimes seven to eight months, and we have to go for lessons and exam you have to pass that exam, to get license… Yeah, and there is some more requirements if you are from a country not English speaking or then you have to show your—fulfill your English requirement as well. (yeah) Yeah, there is lots of requirements. - Ontario, registered practical nurse
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Comments from this RPN in Ontario corroborates those of the previous RPN in Nova Scotia who describes an arduous certification process that required validation of documents from immigrants’ home countries. Additionally, the Ontario RPN notes that there were English test requirements with high score standards if the immigrant was not from an English-speaking country.

For her journey so far, she recounts spending over $60,000 in tuition fees, English tests for nursing and for permanent residence, costs of assessment of education credentials, and cost for license exams. She also talked about the balancing act of juggling schooling, job applications, and permanent residence applications.

Because uh, as—you are immigrant, you have to go through for immigration procedures too. So after your study permit expire—we got a post-grad study work permit… you have certain requirements to get the permanent residence so I was doing that too. So you have to balance kind of that. - Ontario, registered practical nurse

These multiple spheres of immigrant workers' lives increase the precarity they may experience in maintaining a work-life balance. Having to juggle different applications in order to work at a level commensurate with one’s skill can be frustrating for immigrant care workers.

The pertinence of finding and maintaining work in the quest of pursuing certification may also increase their vulnerability to exploitation as they may be willing to endure harsh working conditions to fulfill work-related requirements in the application for permanent residence. Not all racialized care workers had the strength, motivation, and time to navigate the hurdle of certification. In the experience of the health care aide below, despite having international experience, they could not add the complexities of the certification requirements to the burden of navigating a new country and child and family care.
Okay I was born in India then after that, I studied my medicine course in India when afterwards I moved to Dubai, the Middle Eastern country. I was working as a staff nurse, a registered nurse in Dubai in a government hospital when I was there ten years and my husband worked a job here in Canada. So we planned to move out here, build a life so, when I moved here, I tried a couple of times to become an RN in Canada, but my paperwork and everything was delayed and then I gave up a little bit. A long time I had to go back to school them with my family and my kids I don’t have the time and I don’t have financing. I had opportunity to work as a care aide here in A. I’m lucky I’m still in the medical profession; I’m enjoying this position. Now, I’m here almost ten years. - British Columbia, health care aide

After unsuccessfully trying to meet the certification requirements, they were demotivated as their paperwork was delayed. Burdened with the financial costs of pursuing their certification, education, and family responsibilities, they decided to work at the health care aide level as that was more feasible given their multiple responsibilities.

**Coping and Resistance**

One of the pertinent observations made on the field, which was also corroborated by in-depth interviews, is that racialized care workers are resilient people. Though the conditions under which they laboured were challenging, they had agency and chose to give their best to the care work they performed under the most difficult circumstances. They cared for the most vulnerable residents and affectively responded to their needs under exploitative conditions because they cared about the residents they supported. Many of them talked about the love they had for the work and the residents they cared for. Another layer uncovered in the interviews was that some racialized care workers used work in long-term care as a channel through which they could access permanent residency for themselves and their families. That goal ignited a strong will to keep pressing on in the face of adversity.
Again, for others, long-term care home work served as a better option compared to the live-in-caregiver program they were previously engaged in. Thus, despite the precarity and tense work conditions, they resolved to keep pushing through. For many of those who had their permanent residence status or citizenship, working in long-term care enabled them to provide for their families in Canada and their home countries. With their focus set firmly on their goals, most of them were unphased by the harsh conditions of work. They resisted by caring under these conditions because they humanized the process of care as much as they could in a system that often dehumanized care through structural violence. They used humour, their goals, the perception of residents as family, fun, and the invitation of friends to the same line of work as coping mechanisms. Also, team support and support from management made a difference for care workers and reduced the levels of precarity they experienced on the job.

Here the feminist political economy concept of contradictions is most salient. In the exact place of precarity, exploitation, and oppression, care workers, many of whom are racialized, found their voice and assertiveness by choosing to care for residents, themselves, and their families. While their agency under poor working conditions meant that their working conditions would rarely change, they were resilient and worked the most challenging shifts. However, such resilience may be exploited by capitalist and profit-seeking agencies who recruit immigrant care workers to fill in those lower and less desirable care jobs. The cycle here is lucid; with the grip of for-profit and new public management ideas on long-term care homes, precarious working conditions will continue, and the recruitment of racialized care workers will follow in parallel with dwindling and, at best sporadic motivation to improve care. That notwithstanding, the racialized care workers will continue to pursue their agency by unflinchingly resisting and coping under the most precarious
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

conditions of care in long-term care homes. Several factors allow for this process of resistance and coping which are explored below.

**Teamwork**

Teamwork is pertinent to social relations in long-term care work. It helps ease work-related pressure and allows workers to assert some agency over the work they do in a concerted way. Racialized care workers talked about the support their colleagues offered and how it made a difference. Authors like Armstrong, Armstrong, and Choiniere (2015) and Banerjee et al. (2012) have emphasized the importance of teamwork in improving the conditions of work in long-term care.

Beyond teamwork, Armstrong, Armstrong, and Choiniere (2015) advocate for the right staffing mix, which would account for experience on the floor. Though that may be unlikely given the current shortage of workers in long-term care, racialized workers mentioned that good teamwork makes a difference on the floor and improves their experience as care providers. Comments from an Ontario PSW described the pertinence of teamwork in long-term care homes.

> We have a good team here and we help each other. Like we divide two people in the other side and two staff in the other side. So if the other side is done, (mmhmm) finish early, so we tend to help the other team. So we have that kind of uh, good teamwork on this floor. - Ontario, personal support worker

While the lack of autonomy over work organization has been noted among health care aides and personal support workers (Banerjee et al., 2015; Daly et al., 2015), the participants of the study mentioned that teamwork allowed them to support each other. As explained by the personal support worker above, though the entire workload was divided between two groups, care workers
recognized the peculiarities of the work environment and acknowledged that the same numbers did not imply the same workload.

They developed workarounds to support one another on the job. Many racialized care workers described this collegial support as important in reducing work-related pressures that may be caused by falls, sickness, and sometimes covert and overt racism. A racial registered nurse describes the experience of having her colleagues stand up for her during a racist encounter. Responding to a question about whether they experienced racism in the form of name-calling, they recount the experience below.

Yeah, sometimes, uh, but that’s okay. I’m—I’m used to it, like I know it’s not—it’s not part of who they are—(it’s not—) but—well my coworkers are—I find it upsets them more than it upsets me. They are like (yeah) no she’s not—you’re not supposed to do that, and they—they right away correct them… come to my defense—I’m like, that’s okay, I (hmm) but they are like—no. That’s not accepted here. (yeah) And they kind of correct the residents right away… I feel happy that they stand up for me (yeah) but I’m like, that’s okay. I’m not—(yeah) I don’t get upset because of it, (no) but that’s okay.

The racialized RN above describes being supported by her colleagues when residents made racist comments against her. She appreciates them standing up for her. She rationalizes the experience as stemming from dementia, which she believes impairs the cognitive abilities of residents. Thus, she mentions that it is not part of who residents are. This rationalization of racist encounters is a theme that was consistent across research sites and among racialized care workers on different levels of the occupational hierarchy. Hierarchy could have played a role here as the experiences of lower-ranked care workers in the occupational hierarchy were not the same.

Though they talked about the benefits of teamwork and the possibility of switching with team members when residents refused care or were agitated, they did not mention colleagues standing
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

up for them. This did not in any way delimit the pertinence of teamwork to racialized care workers. The words of a BC health care aide captured a resounding experience from participants of the study succinctly when she said, “… when you have the good co-workers, you feel like home, and the residents feel like home. Because this is their home. Their last destination in their life, so they need to feel like home…”.

Working with good co-workers has a ripple effect not only on racialized care workers and their experience on the job but on their ability to provide good care for residents. Here, home is used figuratively to describe the feeling of comfort and welcome at a facility. When racialized care workers feel compassion, they extend that feeling to residents.

Resisting through Care

Another theme that was consistent across study sites was racialized care workers coping with the harsh realities of structural violence in the work environment by caring for residents under the most challenging conditions. Racialized care workers talked affectionately about their relationships with residents, their love for the work, and how they saw residents as their families. From their description of the processes of engagement during care, it was evident that long-term care work was emotional labour in which they were invested. Though the job was difficult, they went the extra mile to provide good care for residents. An Ontario PSW mentions that she put in the effort to uplift the spirits of residents.

I dance for my residents. I do crazy stuff with my residents because I want them to feel at home. This is their home. So I want them to feel at home. So I just treat them like they are my family member and I give them best care, entertainment, the best way possible - that I know how. - Ontario, personal support worker
The personal support worker recounts dancing and trying their best to make residents feel at home. She proceeds to talk about how she sees residents as their family members and tries to entertain them. These stories were similar across all research sites. Working conditions did not deter racialized care workers from investing their emotions into the work they did. They resisted the dehumanized conditions of work that compelled them to be task-oriented by caring for the needs of residents compassionately and with genuine interest. Comments from a licensed practical nurse in Ontario fleshes this out.

I’m the nurse here on one floor and we have 32 residents. It’s like go go go. It’s not sometimes days are quiet—sometimes if anybody is sick you have to—on top of your daily routine work, you have to do more work, like—sort of like—because—you don’t want to leave anybody—it’s—it’s your heart sometimes. You have to put your emotions in there, your heart—you want to make them safe. You don’t want to leave them, like, to suffer. That’s—no. I think any nurse, they don’t work, let them suffer, we have to—whatever we—in our power to do, we—try to do. - Ontario licensed practical nurse

The LPN recounts being incredibly busy when a resident is sick as that incident upsets their work routine. That notwithstanding, she mentioned putting her heart into the work and doing what it takes to keep residents safe and relieved from their suffering where necessary. The compassion she describes here demonstrates how she feels about the residents she supports. This theme of remaining connected to the process of care and resisting oppressive conditions was consistent across research sites.

Racialized care workers brought their hearts to work; although the elements of structural violence attempted to disembody the process of care, they resisted it by humanizing the process, thinking compassionately about residents, and working to meet their needs. They did not merely provide the tasks necessary for care but were emotionally invested in the care process and were
significantly impacted when residents passed. An Ontario PSW recounted how she felt when a resident was in the palliative phase. She explained, “Yeah, even the residents who walking, you know what? In my mind like I don’t want to see into the point that comes to the point that she is in bed and dying. It breaks my heart.”

Here the racialized care worker explains how it breaks their heart when a resident they care for declines functionally or are palliative. With the number of deaths she had witnessed at the facility, she was vicariously traumatized and struggled with thoughts about the impending death of residents, which broke her heart.

These care bonds were noticed across research sites in all three provinces. The cultural shock that racialized care workers in Nova Scotia described stemmed from the care bonds they had developed with residents. In Ontario, a personal support worker talked about how she perceived residents as their families because they were away from their biological families. She explained, “Yeah, like me, I’m a Filipino and away from my family, right? So working in this place with elderly people, I feel like I’m taking care of my own parents. So it’s my main thing, is why I chose to be in this facility in this kind of job”.

As noted above, the personal support worker mentions that they perceive residents as their family, and that was their main motivation for working in long-term care homes. This is particularly telling because it allows them to overlook the conditions of work and respond to the care needs of residents with affection as they identify with them on a much deeper level. Also, they are able to tap into and experientially connect with the vulnerability of residents, some of whom may not have family living close by. Similar stories were also heard across other research sites, especially in BC,
where racialized care workers described the love they had for residents and the work they did in caring for them.

**Strategic Permanent Residence, Family Reunification, and Support**

Apart from the emotional investment, resistance, and teamwork that provided the motivation for racialized care workers, an important incentive for many racialized workers coming into the long-term care home sector was the prospect of acquiring permanent residency. In the permanent residence application, most care workers included their families, thus creating an opportunity for family unification.

Though the pathway to long-term care home work was different for care workers across the three provinces, the goal of working to provide opportunities for family reunification and support was consistent. For instance, in Ontario, the group of racialized care workers was diverse and included refugee claimants, care workers with international experience from the Middle East, and a visitor’s visa holder who married to gain access to permanent residence. In Nova Scotia, most racialized care workers had moved from Ontario to the province after their college education, intentionally to gain permanent residence for themselves and their immediate family.

In British Columbia, they were mainly live-in caregivers who had transitioned into long-term care home work for better remuneration to support their family. No matter their trajectory into long-term care work, most of the care workers had either a nursing background or had at least been involved in caregiving for seniors and children. Focusing on the goal of immigrating to Canada and supporting their families, racialized care workers braved the poor conditions of work in long-term care homes. Also, for those transitioning from live-in caregiving, the remuneration was better than what they had previously earned as a live-in caregiver.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

As indicated by the LPN below, the main reason for their move from Ontario to Nova Scotia was to obtain their permanent residence. The process in Ontario seemed more complex, and the Atlantic Pilot program at the time offered an easier route to permanent residence for them. The LPN explained succinctly, “So I was looking to get my permanent residency. It was easy to move to Nova Scotia to get the PR… So that’s the main reason I moved to Nova Scotia, to get my PR.”

The LPN described a smooth process in the application for permanent residence in Nova Scotia and the opportunity to add their wife and newborn son to the application. As a family, they were able to enter Canada under the family class application. Similarly, an Ontario PSW described moving from Saudi Arabia to Canada because of the opportunity to live permanently with her child. She entered as a live-in caregiver and then transitioned into long-term care home job.

I actually worked uh, in Saudi Arabia first for four years in a hospital there, and then I have one child, which is—it’s impossible for me to get my son and be immigrant in Saudi Arabia, because there’s no—there’s no like, immigration now, or something uh permanent residency in Saudi Arabia. So I just work there and then go home. So for me and my son, this start a new life together, it’s impossible, right? I can’t really start new life in the Philippines because it’s nothing there for us. And then uh, I decide, one of my uh, friend, came to Canada first and then she said to me, why don’t you come to Canada? And then she said there’s a big opportunity for you and your son to start a new life here. So, and then she knew uh—um, a caregiver, um, thing here, so I applied to that caregiver thing and then um, yeah, I got hired… I’m working as a nanny, a childcare, and yeah, from Saudi Arabia, and then flew to uh, Canada to work as a nanny. Yep. Yep. - Ontario, personal support worker

Explaining their motivation for moving to Canada, the PSW talks about the opportunity to start a “new life” with her son, which she felt was impossible in Saudi Arabia, where she was previously employed, and in the Philippines, their home country. Hence, they move to Canada after their friend’s advice. She applied to work in Canada as a nanny, after which she transitioned into
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

working in long-term care homes. She explained that she had to meet a set of rules governing the live-in caregiver program before she could move on.

This story was similar to the experience of other care workers at the same occupational hierarchy in different provinces who had entered through the live-in caregiver program. Many care workers chose to move on from the program once they had fulfilled their contractual obligations. As a health care aide in BC explains below, the motivation for transitioning from the live-in caregiver role to their current position in long-term care was the remuneration. She said, “…. money is more than what I did before [live-in-caregiver]. And then, of course, I love to look after seniors because it seems that my grandparents and my parents.”

The health care aide above explains that the remuneration she received as a health care aide was better than what she received as a live-in caregiver. Also, she recounts that she loves caring for seniors and perceives them as her grandparents and parents.

She would later explain in the interview that she cared for seniors and children as a live-in caregiver, so the transition to long-term care was smooth. Though the transition might be smooth for some care workers, there are contractual obligations which must be fulfilled before the transition. Racialized care workers may experience the transition differently depending on how they are situated. An Ontario PSW fleshes out the trajectory of her transition from live-in caregiver to her current role and the complexities involved in the quote below.

Well uh, after I finish my uh, live-in caregiver, which is, they give us at least a approximate 36 uh, something months to finish and to be an immigrant or apply an open work permit, so when I got my open work permit… I apply, I went to the school for PSW cause that’s the time, it’s the pick uh, job here in Canada, and for me to work—I mean, go to school for four months or six months, I can still help my family—send money my—in the Philippines, right? So I only can take only approximate, like 6 months
for me to send money to Philippines, so that’s why I did as PSW, and then I live close by here so I just bonus because I just walk from yeah, at the same time when I’m going to school, at the same time I’m doing my volunteer here, it’s the same thing, it’s bonus for me, so when I finish my PSW and I apply here, they uh, hire me because I already did the volunteer here. - Ontario, personal support worker

She explained that she was given 36 month or 3-year period after fulfilling her live-in caregiver obligations to apply for an open work permit or for permanent residence in Canada. She chose the prior with the goal of transitioning into long-term care home job because it was a shorter route to work and allowed her to support her family. Clearly, the financial obligation to her family influenced her decision to pursue this path. Also implicit in that choice is the potential to apply to immigrate to Canada with her son as she had previously discussed.

In her experience, she had an opportunity to volunteer at a long-term care home close to her home, so she applied to the facility right after completing her studies. These comments bring to life the theme of permanent residence, family reunification, and support, as well as underscore the vulnerable positions and agency of many racialized immigrant women in Canada. Racialized immigrant care workers assert their agency when they take advantage of existing opportunities to move to Canada. As described in the quotes above, it is the opportunity for a better life for many. They pursued work, which granted them the eligibility to apply for permanent residence for themselves and their immediate family. Because of their positions in the care economy, they are unable to secure the best employment opportunities, but they continue to push forward, as demonstrated in the move from live-in caregiver position to health care aide or personal support worker position. Others, after being accepted as health care aides continued to push through for nursing certification to move up the occupational hierarchy. Though conditions of work in domestic households, in the case of live-in caregivers, and in long-term care homes are
undesirable, they continue to do their best to support themselves and their families and showing an incredible amount of resilience every day (England and Dyck, 2012).

**Inviting friends to Work in the Sector**

Another way racialized care workers coped with conditions of work in rural and small-town long-term care homes was by inviting friends to work in the sector. This theme was consistent across all research sites but was most noticeable in Nova Scotia, where former students at a college in Ontario invited their friends to join them in the province once they were done with their education. From interviews with study participants, it was apparent that racialized care workers had made a conscious effort to invite friends over for two main purposes.

First, was for the opportunity to gain access to permanent residence and, second, was to improve their numbers at the facility. More numbers at the facility allowed for collegial bonding, as many of them were from the same parts of their home country, where they were employed as registered nurses. A registered nurse in Nova Scotia notes below that they were invited by their friends to work in Nova Scotia with the incentive of acquiring their permanent residence, which they obliged to because it was easier to gain permanent residence in Nova Scotia compared to Ontario, where they had received their education.

> Actually, my friend was here so they told me for getting the PR; Ontario was taking two years to two and half years. But here the processing was only one year the I’ll get the PR. Like I can apply for the PR, so it was easier in Nova Scotia at that time than in Ontario that’s why I moved. It was a big move that time, like most of the students in my college were moving to Nova Scotia. - NS, registered nurse

The comment above reflected the experience of many racialized care workers in Nova Scotia who had moved to the province because of the opportunity to gain permanent residence under the
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Atlantic Pilot Program. The program granted easier access to permanent residence for occupations in demand, for which nursing was included. The registered nurse describes an experience of comradery in the moving process as she moved with several of her colleagues at the same time. She said that “…Like five, six people moved, too, at that time.”

Though there is some uncertainty with moving to a new province, moving with friends lessens the prevailing uncertainty as the burden of risk would be shared. Despite moving with friends, the registered nurse describes the odd feeling of people staring at them when they went out because they were very few in the local community.

> When I moved here in 2014, there were few Indians here. So that time when we went out people were staring at us like they were coming and where are you from? Like why you are here like… Now, I think in *facility* we have more than 30 people working…Yeah, we get together during festivals. - NS, registered nurse

With the frequent invitations and resultant increase in numbers, the nurse described a new feeling of having some presence in the community and being able to celebrate festivals from their home country together in a community church hall fairly close to the area of work.

Moving to a new community with friends and inviting others to join them was a unique way of asserting themselves and their agency in a new environment. In the face of white dominance and living and working in white environments, standing with others similarly positioned allowed racialized care workers to build unity, keep their focus and endure poor working conditions. They were able to share their experiences and build solidarity in their struggles together. Part of resisting poor working conditions and pushing through on a daily basis was coping through humour as discussed below.
Humour

Humour was one coping strategies racialized care workers used to neutralize the experience of overt racism in long-term care homes. Humour was also used as a way of making light of working conditions and the general experience of work in long-term care homes. Many care workers use humour as a stress reliever and a way of finding joy in the workspace. In our interviews, they laughed as they recounted several aspects of their work and care relationships in the care home. In line with the many normalizations of violence, sometimes racialized care workers used humour to water down overt racist comments from residents. This is particularly evident in Nova Scotia, where a significant group of racialized care workers laboured at one facility, many of whom were connected through friendships and country of origin.

For instance, an LPN from Nova Scotia recounted during the interview that they laughed at racist comments from residents. When asked about racism, he said that “…some of them have some signs of racism… We laugh at it”. The LPN explained that they laughed when residents called them negative names or said he should go back to his country. Though he was not pleased with such words from residents, he made light of the experience and kept his sights on caring for them. The language used here is “we” which subtly implies community and the sharing of experiences in the racist encounter. Again, “we” denotes that there is some form of solidarity as they share and navigate care relationships together as care workers.

Taken together, these findings demonstrate that long-term care work is difficult work and that racialized immigrant care workers are positioned to experience some of the worse aspects of long-term care work under deplorable conditions. The pressure of family remittance, the non-recognition of their credentials, and temporary immigration status, among other things, shape their
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

position and make them susceptible to exploitation. The findings also present a clear contradiction as racialized immigrant care workers continue to compassionately care for residents and reap rewards of satisfaction in the care process. Again, the study revealed that the opportunity to acquire permanent immigration status and support their families spurred them. They also invited friends into the long-term care sector to build community, share opportunities and continue the process of resistance.

Concluding Thoughts

The findings demonstrate that care work at the frontlines is designed to exploit racialized immigrant care workers. The demand for labour and low educational requirements makes long-term care work an attractive path for immigrants seeking permanent residency or gaining Canadian experience in healthcare. However, the sector's structural limitations, such as inadequate funding and casualization, along with increasing for-profit involvement, contribute to poor working conditions that adversely affect the health of immigrant care workers and exploit their financial, citizenship, and family status. Despite these challenges, these workers find some psychological rewards, such as a sense of satisfaction, meaning and belonging, which are lacking in other available job sectors. The findings also highlight the agency of racialized immigrant care workers and uncover their coping mechanisms and resistance strategies within the oppressive environment of long-term care homes. These include teamwork, compassion for residents, immigration opportunities, family support, building a community of racialized workers, and humor.
Chapter 8: Towards Equitable Labour Processes

This chapter brings the findings into conversation with the extant research and traces the connections between the individual experiences of racialized immigrant care workers and oppressive labour processes in neoliberal Canada. In this chapter, I argue that immigrant care workers are exploited in rural and small-town long-term care homes because of how they are situated in care homes. Also, I argue and demonstrate through my findings that the existing deplorable conditions of work for all workers are exacerbated by everyday experiences of racialization and racism on the job. Finally, I argue that immigrant care workers are resilient and resist oppressive working conditions by caring in the face of adversity, pursuing better immigration statuses, supporting their families, and inviting friends to work in the sector. I conclude the chapter by envisioning ways the findings can contribute to research, policy, and feminist political economy.

Recognizing the intricate complexities of the experiences of racialized immigrant care workers as detailed in Chapter 7 above, this chapter draws on research findings to discuss the subjective positions of racialized care workers in the Canadian care economy and imagine a future where racialized immigrant care workers can participate equitably in a valued and improved care economy.

The study shows that racialized care workers not only worked under precarious conditions in long-term care homes in rural and small towns but experienced exploitation and racism, as well as meaning and belonging, as they negotiated the complexity of transnational living. Across all six research sites, it was evident that racialized immigrant care workers worked some of the most challenging shifts and were frequently relied on by managers to fill short-staffed shifts. Racialized
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

care workers were willing to work those shifts at lower occupational levels where there were frequent staff shortages because of their social location, certification requirements, and immigration status.

The study demonstrates that racialized immigrant care workers are systematically placed in precarious positions in the Canadian care economy and in long-term care homes specifically. As the research literature shows, these precarious positions are the product of capitalist exploitation and neoliberal restructuring which has led to the casualization of long-term care homes and acute shortages of workers in the sector (Baines and Cunningham, 2015; Kelly, 2017; Maier, Meyer, and Steinbereithner, 2016). Also, poor and undesirable conditions of work in long-term care homes have exacerbated the acute shortages in the sector (Armstrong et al., 2020; Estabrooks et al., 2020).

The impact of neoliberal restructuring and austerity measures on the long-term care sector has been felt across many high-income countries (Shutes and Chiatti, 2012). At the same time, globalization and political disruptions have stimulated unprecedented labour migration flows, with care workers as a significant group, moving primarily from the Global South to high-income countries in the Global North and elsewhere (Lightman, 2019). This movement of mostly women has brought many care workers to Canada.

In the Canadian context, there has been an increasing reliance on immigrant care labour to meet the acute shortages of care workers in the long-term care sector. According to Atanackovic and Bourgeault (2013), the acute shortage of workers and high turnover rates in long-term care is due to poor working conditions, low remuneration, lack of opportunities for occupational mobility, and poor public image of the sector. These structural issues and challenges in the sector have been largely ignored amid the ongoing reliance and renewed focus on international care labour as a
panacea for structural inequities. Yet, these structural inequities abound and have been exacerbated by the COVID-19 pandemic (Estabrooks et al., 2020).

This study contributes to the research record on long-term care work in three ways. First, it is one of the only studies in Canada that focuses on the experiences of racialized immigrant care workers outside of major urban areas, where workers are often the only racialized worker on shift and live in communities where there are very few people who share their culture, faith, language, and ethnicity. Second, this study is unique in that it examines long-term care home environments and working conditions within the context of white dominance in Canada. This allowed the study to explore how racialized immigrant workers experience these jobs and work environments and how whiteness can be perceived and, perhaps, challenged. Finally, this study diverges from conventional approaches to feminist political economy analysis by offering a contribution distilled through the lens and experiences of a Black international doctoral student who is seeking permanent residency in Canada. In making this positionality explicit and a point of reflection, it diverges from feminist political economy conventions that veil researchers’ social locations, stakes, and orientations to their topics. It also allows for a more story-making approach to the data than is typical in an effort to produce research that brings participants to life in its pages.

Confirming other research (Banerjee et al., 2012; Lowndes and Struthers, 2016), this study shows the casualization of the long-term care sector has implications for violence (physical, verbal, and structural). Much of long-term care work at the lower occupational levels, where care is more intimate and personalized to the needs of residents, is precarious. Care workers complained about how physical, verbal, sexual, and structural violence were normalized in care homes.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

The physical and verbal aggression that racialized care workers disclosed as a routine aspect of their workday was intimately linked to the substandard work conditions that prevail in many care homes. The study has highlighted the association between precarious shift work and violence in long-term care homes. Racialized care workers, who typically work on a casual basis across multiple facilities, often lack familiarity with residents and their individual needs and preferences. This, combined with other precarious factors that are commonly encountered in long-term care settings, makes racialized care workers particularly vulnerable to experiencing acts of violence while on the job.

The precarious and potentially hazardous nature of long-term care work is well-documented in the literature (Banerjee et al., 2008; Banerjee et al., 2012; Daly et al., 2011). The findings of this study demonstrate that racialized care workers faced heavy workloads while working in long-term care homes, often compounded by frequent understaffing due to acute shortages of workers across the sector. Despite these significant challenges, Armstrong et al. (2020) report an increasing trend of racialized care workers participating in long-term care homes.

The findings of the study provide some leads on why this might be the case for many racialized care workers. The opportunity to gain access to permanent residency, the opportunity for family reunification, the opportunity to integrate faster while providing continued support to their families, the opportunity to earn more income compared to other precarious jobs, and the lack of credentials to work at a level commensurate with their qualifications, were reasons why immigrant workers laboured in long-term care despite the poor working conditions.

Although the opportunity to obtain Canadian permanent residency was regarded as a gateway to a “better life”, it should be acknowledged that the onerous process of credential certification often
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

compelled racialized care workers to toil in lower occupational positions in long-term care homes until their credentials were certified, or they abandoned their pursuit of certification altogether. The notion of care as coercion, which Glenn (2010) explores in depth with reference to the American context, holds significant relevance in this study, where policies such as burdensome credentialization procedures led to the systematic devaluation of immigrant care workers, relegating them to the lowest occupational strata.

The study identified three distinct cohorts of immigrant care workers who possessed registered nurse certifications from their home countries. The first group comprised individuals who successfully transitioned to RN positions in Canada after fulfilling all requisite conditions, while the second group consisted of those who had paused or remained at the level of registered practical nurses (RPNs). The third group was made up of individuals who were unable to progress beyond the position of health care aides due to the demanding certification requirements. Some individuals within the second group expressed a desire to transition to RN positions, while others were less optimistic about their prospects. These trends were observed across all three provinces that were examined in the study, but they were particularly pronounced in Nova Scotia.

Despite facing poor and, at times, exploitative working conditions, racialized care workers exhibited remarkable agency and resilience. According to the study, these workers resisted oppressive and exploitative organizational structures by providing greater care for residents. This process was facilitated by a shared sense of vulnerability, as these workers recognized their marginalized positions within the labor process. Despite this, they approached their work with greater compassion, particularly for residents dealing with multiple comorbidities. They sought to build meaningful relationships with these individuals, engaging in activities such as dancing and
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

bringing joy to their lives, particularly given that many of them were in the latter stages of their lives. For some of these workers, caring for vulnerable residents allowed them to reflect on their own vulnerabilities, particularly in relation to their parents and grandparents whom they had left behind in their home countries.

Collegiality was identified as a crucial form of resistance that allowed racialized care workers to navigate the challenges of their demanding work in long-term care homes. According to the study, these workers highlighted the importance of working together with their colleagues, which positively impacted work organization, performance, and overall job satisfaction. In some instances, white colleagues also demonstrated solidarity with their racialized counterparts, speaking out against racist comments made by residents. Working collaboratively with their colleagues helped to alleviate some of the negative effects of poor working conditions and allowed care workers to better manage their workload. This shared experience of labor and sense of solidarity had a significant impact on the work lives of racialized care workers.

Again, from the study, it was apparent that the goal of immigrating to Canada with their families and the provision of family support was central to racialized care workers’ resilience and struggle. Despite facing precarious working conditions, these care workers persevered and remained dedicated due to the opportunities provided by long-term care home jobs for securing permanent residency, reuniting with their families, and supporting them financially. Despite being coerced to work in the lowest occupational positions in long-term care homes with few alternatives, racialized care workers remained unfazed, as their primary focus was on attaining their permanent resident status.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Additionally, the responsibility of providing financial support for family members in their country of origin compelled racialized care workers to work long hours under precarious and often exploitative conditions. Despite the challenges and potential harm to their health and well-being, many of these women from the Global South viewed this as a means of breaking the cycles of poverty within their families and granting opportunities to their children. As such, their ability to persevere and persist in the face of adversity must be recognized as a powerful act of resilience at the individual level.

Collective resilience also provided a space for racialized care workers to share their experiences and provide support for one another. They were able to share tips on navigating the credential certification process, discuss how to deal with difficult residents and support each other through the challenges of working in long-term care homes. This collective resilience also allowed for the formation of social networks and the building of a sense of community among racialized care workers, which was essential for their well-being and survival in the workplace. This experience in Nova Scotia was particularly noticeable. Racialized immigrant care workers moved to Nova Scotia together and invited others to join them, and in doing so, were able to maintain a presence in an obdurately white environment. From initially feeling stared at to eventually being able to hold community events to commemorate traditions from their home country in rural and small towns, racialized care workers developed solidarity as a group and experienced a journey of being a community together. It is within this context that they shared humour and discounted racist comments from residents and navigated the discomfort of working under poor conditions in white environments.
The experience of navigating systemic racism and unfamiliar cultural territories can lead to increased emotional labor and burnout for racialized care workers (Braedley et al., 2018). They may have to constantly monitor their behaviour and language to fit in with the dominant culture and avoid being singled out or discriminated against. This constant monitoring can be exhausting and may contribute to feelings of isolation and exclusion. Despite these challenges, racialized care workers in the study were able to find ways to resist and assert their agency, often through collective action and solidarity. However, it is important to recognize that systemic racism and cultural barriers in long-term care homes can have significant impacts on the mental health and well-being of racialized care workers. These workers must traverse unfamiliar territories bordering culture, “private” bodies, and class to perform the necessary care under conditions that are sharply opposed to the very essence of care.

The gendered and classed aspects of long-term care homes are also crucial to consider. The majority of care workers in long-term care homes are women, and many of them are racialized immigrant women. Women are often expected to take on caregiving roles both at home and in the workplace, which reinforces gendered and classed expectations of what constitutes “women’s work” and devalues care work as a low-paid, low-status occupation. The feminization of care work also means that it is often undervalued and underpaid, with little room for upward mobility or professional recognition.

In addition, class plays a role in long-term care homes, as many care workers come from low-income backgrounds and have limited opportunities for upward mobility. The low pay, long hours, and difficult working conditions can lead to burnout and high turnover rates, which can ultimately affect the quality of care provided to residents. The intersection of gender, race, and class in long-
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

term care work is a complex issue that requires attention to ensure that care workers are valued and respected for their vital work in caring for vulnerable individuals.

In long-term care homes, women from low-income working-class households, many of whom are racialized, provide care for Canadian women who are living with multiple comorbidities, who themselves might have been part of the working class in the past. Also, many of these racialized women are new immigrants who come to work in long-term care because of the limited opportunities to find work. As work is central to settlement (Valtonen, 2008), some deskill to find work in long-term care homes, especially as personal support workers, due to the high demand for such workers and the short training period of about six months to quality to work at that level. While women make up the majority of workers, Storm, Braedley, and Chivers (2017) demonstrated in their work that racialized men are also seeking employment in LTC as a last resort. These immigrant women and men have similar experiences at work and tend to have similar life opportunities because of how they are situated in the care economy. In what follows, I discuss the implications of the findings for research, policy, and feminist political economy.

Implications for Research, Policy, Feminist Political Economy and Social Work

In the context of the findings above, this section is dedicated to discussing the implications of the study for research, policy, feminist political economy, and social work. These themes are important to my interest in activism as a structural social worker and a Black feminist political economist. Research can be utilized as an extension of the colonial project or at least can be felt that way by oppressed groups (Smith, 2021), so it is pertinent to reflect on research methods in order to ensure that they are rid of any form of oppression. To achieve that, iterative methods that focus on consistently and intentionally reviewing the balance of power should be advanced.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Also, without changes to policy directions in long-term care homes, historical inequities, exploitation, and sheer danger would be exacerbated, as we witnessed at the height of the first wave of the COVID-19 pandemic (Armstrong et al., 2020). Those most affected by policies in long-term care deserve to be heard at the policy table. The consistent sidelining of the experiences of residents and care workers at the frontlines of care exchanges are at the core of unresponsive policies that focus on superficial aspects of problems in long-term care homes. Again, blanket policies like mass recruitment of immigrant care workers without commensurate policies to resolve deplorable systemic conditions would not improve the quality of care in long-term care homes.

Furthermore, I bring focus to feminist political economy because it underpins my study and centers me theoretically. I saved space here to engage with the theory and make recommendations for further theoretical grounding as related to lessons from my study.

Finally, as a structural social worker with commitments to social justice, and I reflect on the potential benefits of my study to social work practice. Immigrant populations and their settlement have are an important aspect of social work practice in Canada, as have long-term care matters. My study contributes to knowledge on care work and immigrant workers and provides valuable insights that can shape social work interventions systemically and locally in long-term care homes.

Research

In the past, research has been utilized as an oppressive tool against the most vulnerable in society (Smith, 2021), so it is pertinent to critically evaluate how we go about our approach to inquiry. The team-based rapid ethnography method utilized in this study was an excellent approach to inquiry as I observed it in action, though with its own limitations. As a novice researcher in the
Canadian context, it was a great opportunity to work with well-established researchers and writers to learn from them firsthand throughout the research process. Informal conversations, lunch walks, dinner chats, long car drives, debrief sessions, and team meetings provided opportunities for group synergy and cohesion.

These excellent attributes of the rapid team-based ethnography method can be streamlined and refined by conversations about racialization and culture throughout the project. Such conversations would not be outside the purview of the method as the method itself is grounded in feminist theory and ethnography (Armstrong and Armstrong, 2018). As a team, we sought to investigate how racialization and culture manifested on the research site but did little to intentionally address these dynamics as they played out in our group. There were some dinner conversations that brought up issues related to culture and class, but they were more of questions than deliberate attempts to attend to race or class.

In future research endeavours utilizing the rapid team-based ethnography method, teams should be deliberate about opening safe spaces to discuss gender, race, and class throughout the research project, as these social relations shape group dynamics and present opportunities for deeper group cohesion. Researchers must not be eager to inquire without being reflexive of their process and of themselves and their teams. Iterative processes should begin with the researcher and team before participants in the research field, as the best way to know is one that is grounded in knowledge of the “self”. It was through my critical reflexivity in the research process that I recognized parallels between my experiences as a racialized researcher on a predominantly white team and the experiences of racialized care workers in rural and small-town Canadian long-term care home
settings. This allowed me to understand the subjective positions of research participants better and to be more compassionate in the process of inquiry.

Also, more emancipatory methods that include research participants throughout the life of the project could open up new ways of knowing in rapid team-based ethnography. Arts-based methods and participatory methods like photo voice could provide interesting opportunities for collaboration with residents (Evans, Robertson, and Candy, 2016) and immigrant care workers. Lowndes and Braedley (2018) caution researchers about the limitations of utilizing photovoice in institutional settings like long-term care homes because of ethical restrictions and logistical challenges. They recognized some interesting possibilities for its usage, nonetheless. Authors like Sethi (2016) have utilized photovoice in evocative ways to bring to focus the lived experiences of immigrant care workers, so there are definite possibilities for rapid team-based ethnography. Residents and immigrant care workers would be more expressive and engaged with these methods and would be able to contribute to what we learn and how we learn.

Policy

As an activist researcher, I consider research findings as tools that can be utilized in making policy recommendations and envisioning new opportunities to ameliorate the circumstances of our lives. From the findings of the study, long-term care homes as publicly accessible goods must change substantively for the quality of care to improve. Across all research sites, racialized care workers complained about physical, verbal, and structural violence in the context of excessive casualization of work, where they consistently worked short-staffed. The research findings also revealed that white environments, culture shock, low remuneration, arduous credential requirements, and racism intensifies the precarious working conditions in long-term care homes. Despite the important
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

historical and ongoing support of immigrant care workers, significant shifts in policy directions are needed to ensure the quality of care and work in long-term care homes (Estabrooks et al., 2020). As new immigration strategies aimed at recruiting immigrant care workers into long-term care homes emerge, commensurate efforts must be placed on improving the conditions of work and care.

The future of long-term care is now, and a strong political will across all levels of government is required to bring the needed change and desired quality to long-term care homes. Adequate investment into time-to-care hours, staffing mix, and remuneration must take center stage in policy discussions if residents in care homes are to live with dignity and respect. Again, a strategic policy shift from the casualization of the long-term care labour force to more permanent, well-paid, secured jobs should be pursued.

Credential validation processes must be expedited in Canada. Though it is important to validate credentials from different countries to ensure competency, consistency of practice, and avoidance of fraud, among others, there is no excuse for the complex and cumbersome credential evaluation processes in Canada. They serve as an oppressive tool Canada uses to consistently plunge immigrant care workers into precarious employment positions and to deskill them to low levels of employment in the care economy. Deskilling and funneling immigrant care workers into precarious occupations is not a new phenomenon, as it has been explored in detail by authors like Duffy (2011). However, the nuance the credentialization presents is worthy of attention, especially in long-term care. As demonstrated in the study, immigrant care workers are coerced to care at lower levels of occupational hierarchies while they wait to validate their credentials. While some are able to progress, many end up giving up as the challenge of credential validation exacerbates
other challenges and responsibilities in their life. The Canadian government must endeavour to expedite the credential evaluation process, especially with the difficulties and uncertainties that COVID-19 presents to the health system. Canada needs immigrant care workers to support the care economy, and reducing onerous credential evaluation processes would allow more immigrant care workers to work at levels commensurate with their competency. This could be an incentive to work in long-term care homes and the care economy as a whole.

In addition, there is a pressing need for changes to be made to long-term care policies at the organizational level. To genuinely recognize and appreciate the invaluable contributions of immigrant care workers, care homes should endeavor to create space that acknowledges and celebrates their inclusion. Such a fundamental shift in organizational culture would be instrumental in attaching value to care while extending that value to the labor of immigrant care workers. It would be a grave mistake to recruit immigrant care workers into long-term care homes without providing them with support and an understanding of the local context. Instead, mentorship programs can be developed to provide support for new immigrant care workers in these homes, and cultural symbols or special events that reflect the preferences of immigrant care workers can be incorporated as a way of recognizing and celebrating their efforts. As my research has demonstrated, the visual elements that are present in long-term care environments have the power to transcend physical spaces to social relations. Additionally, policies targeting racism at the facility level can help to alleviate some of the difficulties faced by racialized care workers, who should not have to navigate the perils of everyday microaggressions or the phenomenon of everyday racism, as theorized by Essed (2002), without adequate support.
Racism at Work and Feminist Political Economy

As demonstrated in the study, racialized care workers experienced being othered not only in everyday microaggressions and by policies that placed them in precarious positions and exploited them, but also by the exclusionary environment within which they laboured. When a white-settler resident says to an immigrant care worker, “You Indian bitch, go back to your country”, they are being racist and sexist. However, the comments advance what already exists subtly on walls and in policies, and points to the othering of the racialized care worker in white environments in long-term care homes.

This study reveals the tensions that emerged at long-term care homes when racialized care workers moved from one occupational level to another after validating their certificates. There was some animosity among white colleagues who had seen some racialized care workers move from the health care aide level to the licensed practical nurse or registered nurse level because of the implications for superiority. They began to participate in discrimination based on accent and distanced themselves from their racialized colleagues. Racialized care workers began to feel the chilliness (Sandler, 2005), and it is within that context that they mentioned that “some of them like to work with their friends”. Here we observe the psychic advantages of whiteness (Nkomo and Ariss, 2014) as white care workers though they were labouring under similar precarious conditions as racialized care workers, could distance themselves and, in some ways, assert their white identity over racialized care workers. The role race played in shaping the experiences of racialized immigrant care workers is clear in this context.

Also, although the congregation of racialized care workers at the bottom of the occupational ladder tells something about gender and class, it is race that crystallizes their experiences altogether. To
EXPLORING THE EXPERIENCES OF RACIALIZING IMMIGRANT CARE WORKERS

capture this dimension more clearly feminist political economy needs to continue to develop its analysis of race, especially as it pertains to exploring the subjective experiences of racialized people. Long-term care work is predominantly considered women’s work, and now more so racialized women’s work; it is undervalued and underpaid, with implications for class positions and experiences. As demonstrated in the study, immigrant care workers across all jurisdictions had more in common in terms of their experiences than they did differences. However, racial markers stood out as workers expressed their experiences in rural and small-town long-term care home spaces. From the physical environments to covert and overt racism, from tensions to the chilliness in the organizational climate, they sensed racism in social relations.

By using race as a lens in these contexts, we may gain greater clarity and insight into the complex interplay of gender, race, and class as analytic categories. This study underscores the value of delving deeper into the analysis of gendered disposable labor in long-term care homes. Across all provinces examined, a consistent pattern emerged whereby immigrant care workers were directed towards the most precarious and underpaid positions, characterized by deplorable working conditions. This observation highlights the existence of longstanding and ongoing labor migration patterns inherent in the continuous recruitment of immigrant care workers in the Canadian care economy and long-term care.

The mundane social relations and experiences of immigrant care workers cannot be separated from the larger global patterns of exploitative migration that recruit and exploit immigrants in Canada and other high-income nations (Anderson and Shutes, 2014). The feminist political economy can play a pivotal role in elucidating these global and local exploitation patterns and establishing links between immigration policies and the everyday life experiences of immigrant care workers. It is
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

essential to unveil the exploitative policies that rely on immigrant labor as cheap and dispensable labor without addressing the systemic issues within the care economy. At the height of the COVID-19 pandemic, the disturbing recurrence of these exploitative policies was reminiscent of past crises. However, amidst the grip of neoliberal political ideals, the political will to reform long-term care seems to be waning, and the memory of the mass deaths has been erased. It is now more crucial than ever to conduct a feminist political economy analysis to steer strategic policy directions in long-term care.

Social Work
The research findings have significant implications for social work practice. As an interdisciplinary field, social work is dedicated to promoting social justice, addressing prevailing societal concerns, and advocating for the most marginalized in society, including immigrant populations. The historical underpinnings of activist endeavors aimed at ameliorating the living conditions of immigrants played a central role in shaping the evolution of the social work profession. Engagement with new immigrants was exemplified through the contributions of pioneers of the social work profession like Jane Addams, who actively championed immigrant causes. The insights generated by this study possess the potential to enhance the practice of social work in multiple dimensions.

Primarily, the study offers a wealth of insights into the experiences and challenges confronted by immigrant care workers in long-term care homes. These insights stand to empower social workers in their efforts to advocate for improved working conditions for immigrant care workers, consequently leading to improved quality of care within long-term care homes.
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

Furthermore, the knowledge derived from this study can effectively inform social work interventions targeted at nurturing the care relationships within long-term care contexts. Recognizing social workers’ integral role in care homes, encompassing support for families and residents transitioning into care homes’, this study’s findings will enable them to create deeper connections between residents and care workers to improve the overall experience of residents.

Additionally, with knowledge from this study, social workers can develop cultural competence which is crucial for effective engagement with immigrant communities. Many immigrant care workers relocate to Canada with their families and may need compassionate culturally sensitive social work interventions. Insights from this study can help social workers understand the complex layers of immigrant lives and how work shapes their lived experiences. Children of immigrant care workers may have different care needs and life experiences that are shaped by low family income and limited opportunities, and social workers must be sensitive to these dynamics as they support them.

Finally, the study equips social workers with a robust base for advocating for labour rights and social justice on behalf of immigrant care workers, particularly those working in rural and smaller communities. By collaborating with unions and participating in activist initiatives, social workers can effectively address the multifaceted vulnerabilities experienced by immigrant care workers. Additionally, the study’s findings can serve as a basis for challenging stringent certification prerequisites that inadvertently perpetuate the relegation of immigrant care workers to lower strata within the hierarchical structure of long-term care homes.
Conclusions

The goal of this study was to highlight the experiences of racialized care workers in rural and small-town long-term care homes. As part of the Seniors Adding Life to Years project, data for the study was collected across three provinces, namely, Ontario, Nova Scotia and British Columbia. The research questions that guided the study were: (a) what are the everyday life experiences of racialized immigrant care workers in rural and small-town Canadian long-term care homes, and what implications may this have for the conditions of care for residents? (b) How does white dominance operate in public institutions? What dimensions of white dominance do we see at work in long-term residential care? And how does it affect racialized immigrant care workers in long-term residential care?

These research questions underpinned the study as much as it did my approach to the study. As a racialized man, I inserted myself in this project as my own experiences in Canada are not far removed from the experiences of racialized immigrant care workers. For over eight years while I have been pursuing a doctoral degree in Canada, I have worked multiple jobs inside and outside school to pay for my tuition fees and my sustenance, as well as to remit my family. I have been engaged in social productive labour, working in food production companies in freezing temperatures, in grocery stores, and a few times on the back end of a restaurant as a dishwasher. These experiences taught me what it means not to have your credentials accepted. Yet, I approached this study with humility and curiosity as I recognized the differences between my experience and the experiences from immigrant care workers at the frontlines of long-term care work.
Intrigued by their experiences in rural and small towns in white-settler communities, it was important for me to insert stories from the field that depicted what exactly it feels like to be in those spaces. Again, to underscore these experiences, I document the aspects of long-term residential care in rural and small towns that are white, to demonstrate how whiteness is woven into the core elements of long-term care homes, and how simultaneously immigrant care workers can be excluded in these settings. This approach was supported by critical race theory which validates the lived experiences of people of colour and identifies them as people who are best suited to communicate issues related to oppression and historic exclusion (Delgado and Stefancic, 2017). This study hits home for me because of the many connections and support of mothers, grandmothers, aunties, and sisters from my community who have laboured and continue to labour in long-term care homes. As a structural social worker, I know that micro level relations I describe here are connected to macro level policies which are designed to oppress and limit opportunities for immigrant care workers. Maurice Moreau (1979), who coined the term structural social work, envisioned it as an approach that poses a critical challenge to dominant groups in society who oppress and constrain those considered less powerful.

In this study, I challenge systemic inequities in long-term care homes by exposing the dominance of whiteness and how it shapes the experiences of immigrant care workers in everyday life. I achieve this on three levels by reviewing long-term care settings and how they create whiteness in their environments, reviewing stories that reflect experiences of immigrant care workers together with my experiences from the study contexts, and policies that plunge immigrant care workers into precarious positions in long-term residential care.
So What?

Immigration has played an important role in Canada’s economic, social, political, and cultural development for decades. Canada has one of the highest immigration rates in the world. In 2021, almost one-quarter (23%) of the Canadian population or 8.3 million people indicated that they were, or had ever been, a landed immigrant or permanent resident in Canada (Statistics Canada, 2022). Immigrants play a pertinent role in Canada’s economy by contributing significantly to its gross domestic product (GDP). Yet, despite efforts to promote diversity and inclusion, immigrants continue to face barriers such as discrimination, language barriers, and difficulty accessing employment and education opportunities. This contradiction is lucid in care homes and must be addressed.

As the world struggles with Covid-19 and its multiple mutations, the Canadian long-term residential care has undergone several changes to control the spread of the virus. Canadian Institute for Health Information [CIHI], (2020b) reports that long-term residential care was hit the hardest, accounting for 80% of all infected people in Canada. The horrifying stories, death toll and gross neglect - to the extent of the involvement of Canadian military - placed a spotlight on long-term residential care for many months, across Canadian provinces.

The COVID-19 pandemic brought to light the dreadful working and caring conditions in long-term care homes, resulting in the death of many residents and neglect of others (Armstrong et al., 2020). Amidst the despair, the invaluable efforts of racialized immigrant care workers were crucial in keeping long-term care homes operational across Canada. Notably, in Nova Scotia, asylum seekers were reported to be leading the fight against the pandemic (Ziafiti, 2020). Thus, it is not
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

surprising that strategies to address the acute shortage of care workers in long-term residential care include initiatives to recruit more racialized care workers (Nourpanah, 2019a; Ramesar, 2021).

Although it is problematic to view racialized care workers as rescuers or a panacea for the acute shortages of workers in long-term care homes, this strategic policy direction sheds light on the pertinence of their role in long-term care homes. While racialized immigrant care workers feature prominently on new recruitment strategies designed to meet the care deficit in long-term care, the poor working conditions are yet to take prime focus. The notion of disposability is rife in this context as many western capitalist economies exploit women from the Global South for its unfettered self-interest. It is in this context that I make the following recommendations thinking through the implications of this pre-covid study for a post-covid world.

First, the conditions of work for care workers in long-term care homes must improve. There is a need to increase public spending in long-term care homes to ensure there are enough care workers on the floor, responding to the needs of residents. With the uncertainties of the coronavirus pandemic, it is essential to have enough workers to minimize the risk of infection. Regulated and enforced national standards with a focus on time to care hours commensurate with the needs of residents would be laudable. These standards would guarantee that the right staffing levels and the right mix of staff skills are available on a daily basis to ensure care workers complement each other’s strengths as they care for residents. Again, improving working conditions would require working effectively to minimize violence in long-term residential care as opposed to its normalization.

Additionally, it is pertinent for long-term care homes to ensure there is a stable workforce meeting the needs of residents regularly. By extension, this recommendation would require more full-time
work for care workers and a reduction in casual, and part-time work that situates racialized care workers under the most precarious work conditions. A stable workforce will improve residents’ experience and ensure a familiar group of care workers meet their needs consistently. It was evident in the study that casual care workers could not guarantee continuity of care given the challenge of navigating several homes and many locations across different homes. Proponents of consistency of care believe that despite the contestations around the consistent assignment and its correlation to improving health outcomes, consistent assignment if done appropriately, enhances the relationships between care workers and residents which is essential for quality care (Caspar, Brassolotto and Cook, 2021; Clemens et al., 2021). Care relationships are important in ensuring residents’ last few months or years are worth living and enjoying. These relationships improve the experience of caregiving and care receiving.

Furthermore, the economic devaluation of highly feminized jobs in the care economy must stop, as it is at the core of the poor remuneration of caregivers (Lightman and Kevins, 2021). The Covid-19 pandemic apart from exposing the structural inequities in long-term residential care, showed us the pertinence of care to human existence - a truth long advocated by feminist political economists. Apart from thank you commercials on social media that were widely circulated, there is the need for real investment into care work, especially into long-term care work. It is crucial to recognize that care work is skilled work and that care workers should be remunerated accordingly. Additionally, care work should be recognized as a legitimate form of work, not as an extension of women’s roles as caregivers. Workers deserve decent pay, as they risk their health and lives at the frontlines every day. Racialized workers must also mobilize, advocate for themselves, and build sustainable networks of power to dismantle their oppression. Activism and advocacy efforts can raise awareness of the issues facing racialized immigrant care workers and put pressure on
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS

policymakers to make the necessary changes. This can include organizing protests, lobbying politicians, and building alliances with other social justice movements. They must stand together and push the agenda that, racialized immigrant care workers are not a solution to systemic deplorable conditions of work in long-term care homes.

Also, long-term care homes in rural and small towns must be culturally inclusive and malleable to allow racialized care workers to adapt to these environments and integrate effectively. As noted in the stories from the findings, part of the care experience is cultural. Culture often morphs organically when people from disparate cultures interact. However, with the strict protocols and rigid adherence to policies in long-term care homes, the experiences and cultures of racialized care workers are almost erased. If rural and small-town long-term care homes seek to retain racialized care workers to fill care gaps in their homes, they must be willing to accept, and celebrate and honour their culture as well.

Again, in line with the goal of creating inclusive long-term care homes, care homes must develop lucid anti-racist policies. Long-term care homes must design anti-racist or zero tolerance policies on racism and create conditions for effective implementation of such policies. These policies must among other things have a clear process of addressing racism in a manner that supports and dignifies immigrant care workers and halts potential counter offensive threats or demonization from perpetrators or their supporters. These policies cannot be fully implemented in environments that do not create a general milieu of support and recognition of immigrant care workers, as there is the potential risk of creating veneer-type policies that do little to address deep seated issues. Policies must also name and identify racism in unequivocal terms but also include pertinent
strategies to create learning opportunities for racists and by-standers who in their inaction validate acts of racism.

Creating an egalitarian workplace where racialized care workers feel valued and respected would allow for a smooth transitioning and retention of workers in these homes. Long-term care homes could adopt Inclusion, Diversity, Equity and Accessibility (IDEA) policies and seek to include the perspectives of racialized care workers in the strategic direction of care homes as racialized care workers have more to offer apart from their labour. There should be an ideological shift in long-term residential care from policies that individualize residents and the care process, to a shared communal experience of living and working together. Long-term care homes must shift from “I” to “we”, from “resident” to “community” as we continue to envision an equitable place and space that treats residents and workers with dignity and respect. It is in the process of individualization that the resident, group and institution or home is othered by the Canadian society. The dread of long-term care homes in the public psyche is shaped by these same individualized processes nested in ableism in Canadian society.

Training and education on cultural sensitivity and competence would be important for racialized care workers and their white colleagues in rural and small town Canadian long-term care homes. Cultural sensitivity and competence would improve teamwork which is crucial for work organization, bonding, and comradery. Racialized care workers must be trained on the culture of the local context and provided training modules that would improve their overall experience of Canadian culture. White colleagues must also be trained to work collaboratively with people from diverse cultures. Culturally sensitive training would be necessary for the first few months of employment to allow racialized workers to understand the cultural context of the care home. With
such understanding, racialized care workers would get a good footing on the culture of the local context and be able to relate better with residents, colleagues, and residents’ family members. Long-term care homes can train experienced care workers as peer mentors to guide racialized care workers on the job in the first few months.

Enhancing and nurturing teamwork would improve the conditions of work in rural and small-town long-term care homes. Long-term care homes must intentionally nurture team building to enable racialized care workers to develop friendships with their colleagues. In-facility activities, social events and celebrations may be organized to create group interaction and bonding. From the study it was evident that a significant number of the racialized care workers maintained that teamwork positively impacted their work experience. Through associations at work, racialized care workers can potentially build long-standing friendships and relationships that can transcend work into the local community.

Conclusively, though inviting change into long-term care homes, especially in rural and small towns can be unsettling, there are many advantages that make it worthwhile. Racialized care workers may become residents in the future and equitable care homes would mean that they will be able to call these homes, “home”.

References


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


Canadian Institute for Health Information [CIHI]. (2014). *Health Spending – Nursing Homes.*


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


https://doi.org/10.1038/s41598-019-40914-x


https://doi.org/10.1111/bjir.12466


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


Immigration, Refugees and Citizenship Canada (2022, April 19). Caregivers. Retrieved from
EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 8.


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


Statistics Canada. (2022). Immigrants make up the largest share of the population in over 150 years and continue to shape who we are as Canadians. Retrieved from https://www150.statcan.gc.ca/n1/daily-quotidien/221026/dq221026a-eng.htm


EXPLORING THE EXPERIENCES OF RACIALIZED IMMIGRANT CARE WORKERS


