International Health Trends and Perspectives

Invisible diaspora: A scoping review of migrant caregivers' social integration trajectory

Original Research

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ABSTRACT

Introduction: The Canadian Caregiver program, initiated in 1992, functions to conceal the inadequate public policy and programs on child and elder care in Canada. Consequently, migrant caregivers have become an invisible diaspora filling a domestic labour gap with few protections. **Aim and Methods**: This scoping review aims to identify the systemic barriers that undermine social integration of migrant caregivers. We searched ten publication index databases from 2001-2020. We retrieved 1,551 articles, after accounting for exclusion criteria, 22 peer-reviewed articles were selected for this review representing migrant women across Canada who are and/or were part of the program. **Results**: Four key barriers were identified: economic exploitation, deskilling and downward occupational mobility, asymmetrical accountability, and social isolation. **Conclusion**: Discriminatory policies and hidden exploitative employment practices of the Canadian Caregiver program perpetuate a cycle of marginalization. This review also found that community support groups and alliances function to promote resilience among migrant caregivers through community advocacy.

KEYWORDS

Social integration, migrant caregivers, Caregiver Program

FUNDING SOURCE

This work was funded by CIHR Knowledge Dissemination Grant from the Institute of Gender and Health.

INTRODUCTION

Modern day domestic care work is modelled after historical colonization, displacement, and minority marginalization practices (Castles & Miller, 2009; Parrenas, 2012). Care work is gendered and racialized resulting in, exploitation, marginalization, and social exclusion of migrant caregivers (Cohen, 2000; D'Addario, 2013; Salami & Nelson, 2014; Spitzer et al., 2009). Systemic racism has meant employers reduce workers to their preconceived racialized traits, rather than recognizing their skill and knowledge. For instance, compared to lighter skinned women, darker skinned women are often assigned the least desirable work (Bakan & Stasiulis, 2012). This process can be observed in Canada's Caregiver Program where Filipino women are relegated to providing care for Canadian families in their homes (Callon, 2017). The Canadian Caregiver program, initiated in 1992, functions to divert attention from the lack of universal childcare and inadequate health and social care policies to designed to address the unmet needs of its growing elderly population (Atanackovic & Bourgeault, 2014; Chowdhury & Gutman, 2012). The program allows Canadians to hire highly educated and skilled temporary foreign workers for minimum

  ISSN 2563-9269

wage. In a review of the literature, Spitzer et al. (2008) found that 90% of migrant caregivers accepted in the Caregiver Program are women, with the vast majority coming from the Philippines and a growing number from Haiti as well as African, Latin American, and Asian countries (Hanley, Larios, & Koo, 2017). Most are highly skilled graduates from nursing and teaching, between the ages of 25-44 years (Kelly, Park, de Leon, & Priest, 2011).

According to Tungohan (2013), migrant women face a growing challenge: they have limited economic power in their home countries which forces them to migrate in support of their families, and yet their ability to actively care for their own children is restricted by geographical distance. As a result, migrant women are forced to sustain transient, low wage employment in countries like Canada, deepening loss of identity and exploitation (Parrenas et al., 2015). Canadian governments created, and continue to reinforce, the international division of reproductive labour. Driven by a lack of affordable childcare and inadequate home care system, Canada initiated its migrant caregiver program in the early 1900s through recruitment of foreign domestic workers from Britain and Scandinavian countries. The Foreign Domestics Movement (FDM) was established in 1981 and served to further attract Caribbean women to domestic work in Canada (Tungohan, 2013). The program expanded in 1992 to become the Live-in Caregiver Program (LCP), which offered qualifying migrant caregivers a route to permanent residency after 24 months of work as caregivers. The main qualifications to migrate to Canada through the program is a minimum of one year education in a relevant field as well as experience. This Program was designed to meet a market need for qualified temporary foreign workers (TFWs) to care for children, older adults and people with disabilities while living in the employers' homes.

In February 2019, Immigration, Refugees and Citizenship Canada (IRCC) restructured the pathways to permanent residence as a caregiver. The current pathways are: 1) interim pathway for caregivers; 2) caring for children program; 3) caring for people with high medical needs program; and 4) live-in caregiver program. Changes to the program translate into a more elitist system of recruitment, with fewer opportunities for low-skilled workers, restricted access to permanent residency and emboldened employer participation. Hegemonic citizenship pathways designed to absolve the government from socially inclusive policy compound migrant caregivers' access to sustained resources. Because migrant caregivers enter as temporary foreign workers and are not eligible for permanent residency for the first two years, government programs are directed at settlement (short term) rather than integration. Meanwhile, migrant caregivers are expected to pay taxes and unemployment insurance without access to citizenship integration programs (Stasiulis & Bakan, 2005). Migrant caregivers are put at a disadvantage to integrate into Canadian culture socially and inclusively when they are systemically excluded from protections and opportunities that would facilitate their integration (Cohen, 2000; Stasiulis & Bakan, 2005; D'Addario, 2013; Spitzer et al., 2009). In the context of this article, social integration refers to equitable and sustained access to and participation in resources that support social and economic growth. This article presents data yielded from a scoping review that examines existing literature related to government policies that shape social integration for migrant caregivers in Canada.

AIM AND METHODS

A scoping review methodology was chosen to enhance our understanding of social integration for migrant caregivers in Canada. The framework proposed by Arksey and O'Malley (2005). This methodology was selected over other review designs, such as systematic review, because it permitted us to broadly explore a topic with limited knowledge. Unlike systematic reviews where the quality of studies is considered, scoping reviews are often described as a process of mapping and summarizing the breadth and depth of a field (Levac. Colqhuoun, & O'Brien, 2010). Most importantly, scoping reviews allow for analytical (re)interpretation of the literature.

Arksey and O'Malley (2005) put forward five stages for conducting a scoping review, with a sixth optional stage. Stage 1 relates to identifying a research question, which should provide a breadth of coverage. We aim to examine *what is known from existing Canadian literature about systemic barriers and facilitators of social integration among migrant caregivers?* Stage 2 involves identifying relevant studies and developing a decision plan for searching the literature. We searched ten publication index databases: ProQuest Research Library, Sociology

IHTP, *1*(1), 44-60, Spring 2021 ISSN 2563-9269

Collection, CINAHL, JSTOR, Social Science Citation Index, Google Scholar, ProQuest Dissertations and These Global, Migrant Workers Rights Global, CHHRN-CIHI Library and EbscoHost spanning from January 1st, 2001-December 31st, 2020 to capture the latest literature. We included studies from the perspective of adult women who are current or former members of the migrant caregiver program in Canada. We used both primary and secondary source articles published in English (Table 1).

Books, reports, thesis work and academic articles were all included in this review. We used the following keywords: *live-in caregiver program*, LCP*, federal caregiver program*, migrant/ live-in/ home/ temporary caregivers*, migration and settlement*, social/ economic/ identity integration*, temporary status*, social mobility*, workers rights*, social exclusion*, marginalization*, vulnerability*, access*, health*, deskilling*, Canada*.* Stage 3, study selection, includes the application of post hoc inclusion and exclusion criteria based on the research question and new familiarity with the literature. We made initial determinations of inclusion based on abstracts and titles (Figure 1).

The research team met on several occasions to discuss the literature and make decisions about which text met the inclusion criteria. We excluded studies that examined temporary foreign workers (broadly) as well as studies that exclusively looked at specific health outcomes for migrant caregivers. If there was uncertainty about inclusion, the authors discussed its relevance to the research questions and came to a collective decision. Stage 4 refers to data charting, in this case the authors extracted data into a chart using the following headings: citation, location (denoting a specific province), population characteristics, study design, aim of study, key findings and rationale for inclusion (Table 2). Stage 5 entails collating, summarizing, and reporting results. Our thematic analysis was both descriptively informed by numerical summary analysis (how often/much did a theme occur) as well as qualitative analysis (depth and richness of the theme). The findings yielded from this analysis serve the broader purpose to understand social integration and we were therefore attentive to nuance, power, and privilege.

RESULTS

The results of this review reveal a relative paucity of work on migrant caregiver social integration (n=22). The research articles included in this study used either a qualitative or mixed-methods study design. Data collection spanned several Canadian provinces including Nova Scotia, Quebec, Ontario, Alberta, and British Columbia. Our analysis five themes emerged: economic exploitation, deskilling and downward occupational mobility, asymmetrical accountability, social isolation, and resilience. Table 2 describes each article included in the scoping review. We have further highlighted the major theme that emerged from the research article.

Economic exploitation

Economic exploitation was a recurrent and complex theme that emerged in this review. Several authors described inadequate pay with rates well below minimum wage (Banerjee et al., 2017; Bourgeault, Parpia & Atanackovic, 2010; Chowdhury & Gutman, 2012; PINAY, 2008). Most authors conceded that migrant caregivers were not paid an hourly wage but rather a weekly sum that was not commensurate with the number of worked hours (Gallerand, Gallie, and Gobeil, 2015; Oishi, 2008). In addition to low wages, Gallerand et al. (2015) found that two-thirds of Filipino caregivers included in their study (n=33) immigrated via a third-party recruitment agency, while PINAY group (2008) reported 35% (n=148) of respondents used an agency. Despite this discrepancy, all but 3 studies included in this review remarked on perilous recruitment agencies for migrant caregivers. At best, these agencies were described as providing minimal formal assistance (Bonifacio, 2008) and at worse, provided illegal employment contracts with fake employers (Kapiga, 2009). Furthermore, many caregivers were tied to long-term debts to an employment agency with service fees estimated around $5000 (Gallerand et al., 2015) to $25,000 notwithstanding travel and accommodations (Salami, 2014). While some studies alluded to high remittance fees, there is a lack of data related to how much migrant caregivers spend on remittance. Estimates suggest that remittance costs average 9% in Canada (World Bank, 2014), although they can reach as high at 30% (Report on the Remittance Agenda of the G20, 2014).

Deskilling and downward occupational mobility

  ISSN 2563-9269

The Philippines was described as the top source country for migrant caregivers under the Caregiver Program in several studies (Bourgeault et al., 2010; Kapiga, 2009; Palmer, 2010; Salami, 2014; Salami & Nelson, 2014). Filipino women are often revered as 'national heroes' by local government to encourage outward mobility and local prosperity through remittance (Bourgeault et al., 2010). The majority of migrant caregivers are highly educated. Bourgeault et al. (2010) found 53% of migrant caregivers entering through the Caregiver Program had a bachelor's degree and professional nurses (37%) were overrepresented in domestic work. Kapiga (2009) found 77% of migrant caregivers were university educated and Miller (2010) found that 60% of migrant caregivers in her sample had post-secondary education in the fields of nursing, education, or midwifery. However, professional development for these highly skilled migrant caregivers were truncated (Banerjee et al., 2017). Oishi (2008) describes how many migrant caregivers lose their skills when they are removed from their professional practice; further courses to upgrade skills are very costly for foreign residents. Notably, Oishi also describes how many migrant caregivers turn to informal care work when they lose their self-esteem and self-confidence to practice in their designated field. Bourgeault et al. (2010) notes that while skilled workers are more likely to be selected for the program because of their credentials, they in turn become deskilled in the process, at least temporarily when they are unable to work within their scope of practice. For example, when a Registered Nurse is hired as a migrant caregiver and unable to practice their skills.

Salami and Nelson (2014) critically discuss migration through the Caregiver Program as part of the global care chain, whereby they apply Hochschild's (2002) concept of emotional imperialism which delves into emotional care work that is extracted from the Global South to service the Global North. In their discussion, they note a labour gap that is left in Global South, typically filled by older daughters and mothers, structured by gender, class, nationality and ethnicity. The authors illuminate the downward occupational mobility of migrant caregivers who are required to work a minimum of 24 months in the Caregiver Program before they are eligible to seek employment in their trained profession (Salami, 2016; Salami & Nelson, 2014).

Oishi (2008) describes how many migrant caregivers are recruited to Canada to fill care deficits in the healthcare system but end up being overqualified and working in low-skill work because degrees and training are not recognized in Canada. The downward mobility is further sustained by expensive and often unaffordable professional development opportunities, such as obtaining a nursing degree. Oishi further notes that after the Caregiver Program, many migrant caregivers take on personal support worker (PSW) certifications because they are relatively inexpensive and enable migrant caregivers to work in nursing homes, retirement homes and hospitals. Pratt et al. (2008) note that migrant caregivers typically retain very few resources after the Caregiver Program because they are remitting large sums for family back home while also saving to bring their families to Canada if they obtain permanent residency.

Asymmetrical accountability

Migrant caregivers endure tremendous scrutiny in the Caregiver Program as well as through their process of immigration (Atanackovic & Bourgeault, 2014). For example, in addition to government and employer requirements, Canay (2014) exposes employer surveillance in her narrative research study, noting how employers engage in observation of the migrant caregiver out of lack of trust and stereotypical attitudes contribute to an atmosphere of control for migrant caregivers. Additionally, there are asymmetrical stakes for migrant caregivers compared to their employers. Loss of employment and risk of deportation are enormous negative consequences for migrant caregivers who are terminated. Paling in comparison is the recourse when employers are abusive, who may endure fines or exclusion from the program. Regulatory protection asymmetrically favours the employers. Teeple Hopkins (2016) describes how migrant caregivers are only covered under labour law protections if they are employed through an agency in Quebec. Migrant caregivers paid by families have no protections under occupational health and safety acts, excluding them from Workers Compensation in the event of injury (Teeple Hopkins, 2016). Under federal government requirements of the Caregiver Program, employers are expected to provide third party health care insurance coverage for the first three months when migrant caregivers are ineligible for provincial insurance plans, but only 24% (n=21) did so according

  ISSN 2563-9269

to Carlos and Wilson (2018). Galerand et al. (2015) reported a case where a migrant caregiver was charged expensive rent for their living accommodations. Furthermore, Atanackovic et al. (2014) described circumstances where accommodations did not meet federally mandated requirements, such as having a separate lockable space, but due to a lack of system checks there was no recourse.

Social isolation

Our analysis of social inclusion and integration would be remiss if we did not comment on the overwhelming social isolation that many migrant caregivers experience. Visas obtained under the Caregiver Program prohibit migrant caregivers from bringing family (Atanackovic et al., 2014). Many migrant caregivers endure long separations from their families which take a toll on their wellbeing. Tungohan (2012) also noted overwhelming disconnect from home life, particularly when they have maternal responsibilities at home. Parental obligations as primary caregivers, even while working abroad, generated high expectations for sustaining familial relationships with little control. According to Tungohan , gendered care work is reinforced when migrant caregivers transfer tasks to other female members within the household to cope.

Spitzer (2009) highlights the experience of migrant caregivers living in rural communities in Canada and exposes social isolation associated with constrained access to informal and formal social supports. She describes disruption in settlement and social integration when there is a paucity of social resources for migrant caregivers. Moreover, she notes a lack of autonomy and privacy when migrant caregivers have to rely on their employers for transport to health services, government offices, social gathering and religious services (Spitzer, 2009). Migrant caregiver who lived in smaller homogenous communities reported feeling subjugated by an Othering gaze (Spitzer, 2009). Rather than feeling included and having membership in the community, many described feelings of being exoticized and objectified (Spitzer, 2009).

Resilience

Resilience was an important theme that emerged from our analysis. Despite a lack of citizenship to enable active political participation such as voting, many migrant caregivers engaged through civil society activity, such as rallies and community engagement (Tungohan, 2012). Several authors noted gains through community activism that are relatively unexplored (Atanakovic et al., 2014; Bonifacio, 2008; Kapiga, 2009). Kapiga (2009) identified Filipino community groups as informational and emotional resources to facilitate migrant caregivers' connections to their culture, heritage and language, as well as engendering feelings of unity and belongingness. Organizations such as Filipino Solidarity Cooperative, the Industrial Welfare Commission (IWC) and PINAY (a Filipino word use to describe a Filipino woman living outside the Philippines) were listed as outlets to learn new skills, build confidence and develop social networks. Importantly, Kapiga identified collective organized resistance and inter-ethnic alliances as means to fight for rights and protections. These organizations play an important role in questioning power differentials and regulations that render migrant caregivers socially excluded. There is movement towards unionization among Caregiver Program advocates to address protection and bargaining rights (Kapiga, 2009). Root (2009) notes that the kinship garnered through informal support groups have mitigated symptoms of depression, homesickness and alienation. Furthermore, Root described how spirituality also plays a strong role for the survival of Filipina caregivers against isolation.

Tungohan (2012) illustrates the expansion of definitions of motherhood that ensues from migrant caregiving. While she highlights in depth the toll that transnational hyper-maternalism takes on migrant caregivers and their families, including traumatic family reunification, she also notes the resilience that is harvested when women come together. Specifically, she describes how support networks and counselling groups in host countries assist in challenging gendered norms and societal indifference. This type of advocacy is imperative to combat social exclusion.

DISCUSSION

The results of this scoping review illuminated systemic barriers for migrant caregivers to access equitable resources and rights to civic participation that support their wellbeing, including *economic exploitation, deskilling and downward occupational*

IHTP, *1*(1), 44-60, Spring 2021 ISSN 2563-9269

mobility, asymmetrical accountability, and social isolation. These barriers produced and perpetuated a cycle of low-earning, lack of opportunity, and deskilling. The review also exposed the shortcomings of caregiver pathways for permanent residence geared towards settlement of newcomers over social integration compounded by social isolation. Finally, *resilience* emerged as a fifth theme to highlight community advocacy that exist despite exclusionary policies.

Parrenas (2001) defines 'partial citizen' as a migrant who lacks full integration in the destination country and yet also lacks protections in her country of origin. In Canada, immigrant pathways are built on settlement rather than integration which systematically undermines belonging. According to Parrenas (2001), migrant caregivers mitigate their partial citizenry by reasserting their belongingness to their home country. Childcare, senior care and care for persons with high medical needs continue to be under resourced within the public systems in Canada. Childcare, for example, is heavily reliant on informal supports such as relatives, unlicensed centers and home-daycares due to costs and waitlists (Hanley et al., 2017). Hanley et al. (2017) explain that commodified home-based, low-wage domestic work is encouraged through private markets, particularly in the absence of adequate national strategies and public policy. Furthermore, governments reinforce an informal care system through tax deductions to families in replacement of affordable care options. Underlying the lack of policy is a gendered value system, where men are traditionally visible as wage earners, while women are visible as mothers and occupy private spaces in the home (Crompton, 1999). Because of this value system, there is an enduring acceptance that caregiving is women's reproductive work, which renders it invisible and undervalued (Duffy, Albelda & Hammonds, 2013). Instead of restructuring care work as legitimate, valued and skilled work, it has been shifted to racialized migrant caregivers – as low-wage and low-skilled work. Kelly, Astorga-Garcia, and Esguerra (2009) affirmed this trend in their mixed method study (n=421) that found 66% of migrant caregivers experienced downward mobility and only 11% had found work analogous to their employment prior to leaving the Philippines. A lengthy separation from their profession practice coupled with erosion of their confidence associated with the confinement to unskilled labour contributed to deskilling (Zaman, 2006).

If care work continues to be low-paid or unpaid, asymmetrical accountability will persist. Indeed, reciprocal accountability was non-existent in many situations and became amplified when few or no channels ensured minimal protections for migrant caregivers (e.g., safeguards when policies were not followed by employers). Policy changes based on social justice are required to improve economic and social recognition of care work. Furthermore, movement towards government accountability for safe work environments is direly needed.

Low wages, third-party immigration fees and high remittance rates were all systemic mechanisms that reinforce economic exploitation among migrant caregivers, resulting in intricate power dynamics that sustain such exploitation. Bourgeault et al. (2010) reported how migrant caregivers are prohibited from seeking supplementary employment outside the residence of their employer through the Caregiver Program, and employers are free to terminate employment at any time. Furthermore, due to few employer regulations, the job description of migrant caregiver is often ambiguous, and caregivers are expected to serve in several capacities such as carers, cooks and entertainers. Because of precarious living status many migrant caregivers endure abuse and exploitation to maintain their employment (Atanackovic & Bourgeault, 2014; Banerjee et al., 2017). Compounding the exploitation, there is underlying power system where most employers are middle and upper middle class and hold highly qualified jobs such as doctors, lawyers, professors, and engineers (Gallerand et al., 2015). Paradoxically, Bourgeault notes how the Caregiver Program promotes and exploits cheap labour that transcends economic echelons – particularly in a climate of unaffordable child and home care for many in Canada. Either way, migrant caregivers are filling a labour gap without protective regulation to ensure fairness of their work. Without adequate pay or protection, social integration is undermined – particularly in a neoliberal system, like Canada, that equates worth predominantly with financial viability.

In 2011, G20 countries including Canada committed to reduce remittance fees paid to banks and transfer firms to 5% - which would result in an estimated $11billion USD in the hands of families rather than banks worldwide (Westwood, 2013). Global Affairs Canada has partnered with Statistics

IHTP, *1*(1), 44-60, Spring 2021 ISSN 2563-9269

Canada to conduct a survey to better gauge remittance rates. To date, Canada has not instituted regulations to meet the 5% target, Instead, migrant care work is the Wild West for unregulated employment recruitment agencies that capitalize on low-wage work, charge high fees and make false promises for permanent residency (PINAY, 2008). Their role becomes justified when government policy requires third-party agencies to legitimize care work and qualify for employment protections (Teeple Hopkins, 2016). Such perilous agencies would not be tolerated in high-earning sectors, or at the very least, there would be market controls to ensure fairness (i.e. charging employers for service rather than employees). Through restructuring, these agencies could channel opportunities for new employment, offer professional development and possible routes for unionization. Furthermore, these groups could take on advocacy work such as Canada falling short on its commitment to reduce remittance fees to 5%, as part of its G20 promise (Westwood, 2013).

Despite a relative paucity of work, there was resounding consensus gleaned from the literature that migrant caregivers were relatively unprotected as employees. Indeed, this notion resonates with Salami, Amodu & Okeke-Ihejirika (2016) study that found migrant caregivers were inadequately compensated and unable to afford housing outside of their employer's home, which compounded their fear to report incidents of abuse. Nursing professional associations could play an important role in advocating for equitable health conditions for these caregivers.

The social exclusion and lack of social protection experienced by migrant caregivers is largely structured by immigration policies. Specifically, initial migration to Canada as a temporary foreign worker impedes the social and economic integration of migrant caregivers. For instance, caregivers often have bachelor's degree before migrating to Canada, but they often work in unskilled jobs after the completion of the caregiver program (Kelly, Astorga-Garcia and Esguerra, 2009). Policy implications from our review indicate a need to expand permanent residence pathways for caregivers. Canada is one of a few countries that allows migrant workers to migrate initially as temporary foreign workers and then transition to permanent resident status. In Taiwan and Hong Kong, caregivers migrate as temporary foreign workers on a two-year contract and are unable to transition to permanent resident status (Parrenas, 2001). In many other high-income countries (such as Australia and United States) specific pathways for migrant caregivers that includes initial temporary migration does not exist. Policy recommendations in Canada include the need to ensure migrant caregivers (including those providing child and elder care) can migrate to Canada as permanent resident.

A few considerations have been noted while interpreting findings from our scoping review. Firstly, while we adopted methodology by Levac et al. (2010) we have not shared our findings from this work with stakeholders. Including this step could offer unique insights and help refine some of the findings of this review. Furthermore, we were restricted in our access to certain academic journals and failure to include evidence from such journals may have omitted potentially valuable findings. Since the studies we accessed mainly represented English speaking migrant caregivers, we may be remiss in our depiction of social integration and inclusion for migrant caregivers who do not speak English.

CONCLUSION

This work invites critical discussion and promotes candid dialogue to inform policy changes to optimize social integration. Nurses must advocate for improving social conditions of migrant caregivers by addressing immigration policies that limits the social integration of migrant caregivers. This is especially important given that many migrant caregivers are nurses and many experience deskilling upon migration to Canada (Bourgeault et al., 2010; Kelly, Astorga-Garcia and Esguerra, 2009). Furthermore, it will be important to build on existing community work and resilience, while shifting away from settlement policies designed for short-term circumstances and move towards social integration, particularly given the high labour expectations on migrant caregivers.

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Figure 1: Inclusion/Exclusion Criteria

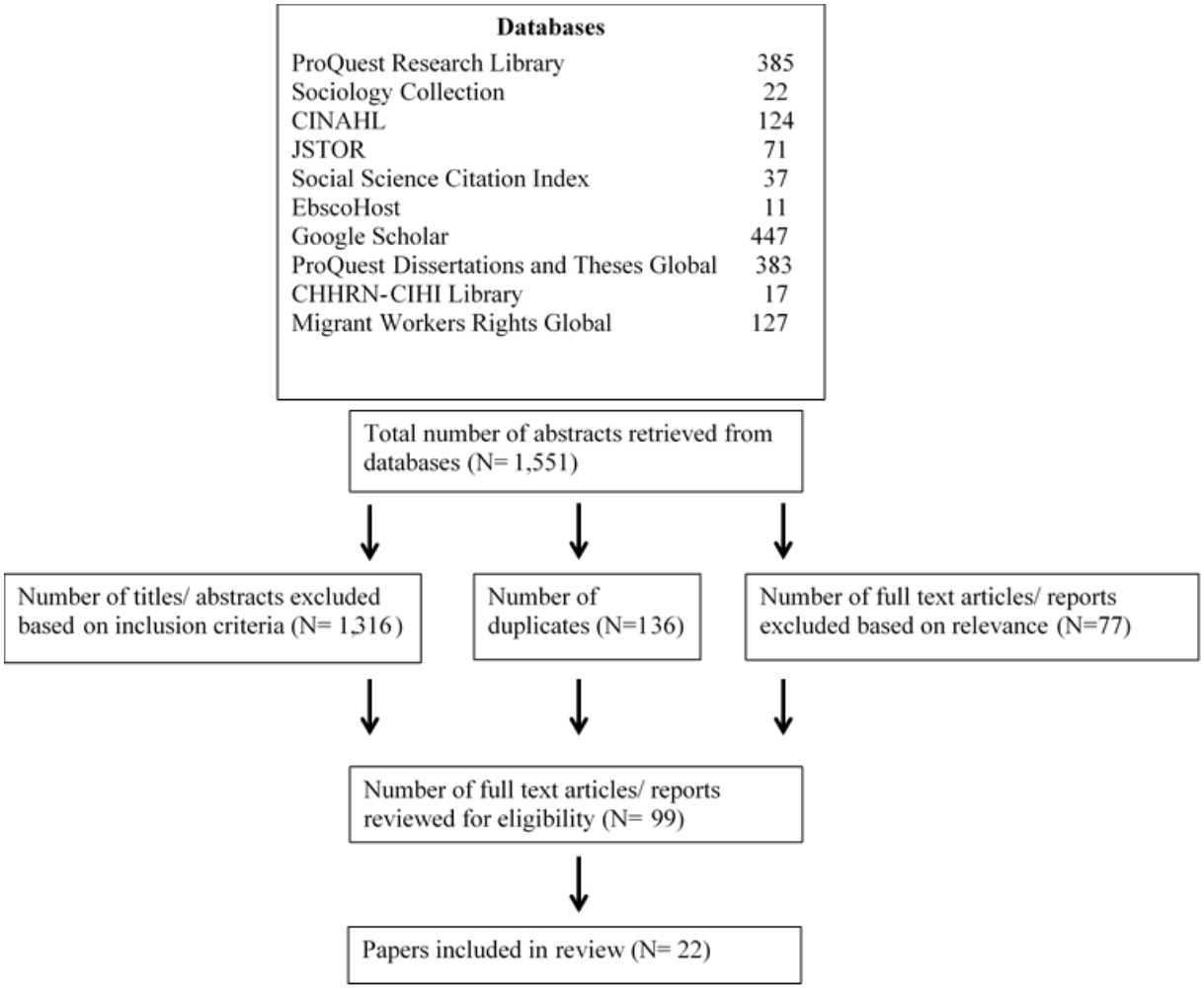

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Table 1: Inclusion/Exclusion Criteria

Inclusion	Population: Former or current members of the migrant caregiver program; age 18+, women, migrants in Canada Type of articles: primary and secondary source peer-reviewed articles, English language between 2001-2020
Exclusion	Population: members of the temporary foreign workers program – not in the migrant caregiver program; age less than 18, males, migrants not in Canada

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Table 2: Study Results

Citation	Location	Study Objectives	Participant Sample	Study Design	Major Findings
Bonifacio, 2008	Southern Alberta	To explore the transitional supports and services used by migrant caregivers while in the Live-In Caregiver Program and services provided by the Philippine government during this period.	30 Filipino live-in caregivers.	Qualitative: Interviews and focus group discussions between 2006-2007.	Economic exploitation Asymmetrical accountability Social isolation
Bourgealt, Parpia & Atankovic, 2010	Hamilton, Toronto, Vancouver, Victoria, Montreal	To contribute knowledge about the experiences of live-in caregivers and perceptions of their relationships with clients and their families.	19 immigrant care workers who came to Canada through LCP who were presently working in a range of different health care institutions: large/ small institutional settings, home services and private households.	Qualitative: Semi-structured interviews and two focus groups between 2007-2008.	Economic exploitation Downward occupational mobility Social isolation
Chowdhury & Gutman, 2012	British Columbia	To further understanding of services provided by LCP elder care workers, the nature of employer-employee relations, as well as their experiences and perceptions as migrant care workers. To understand the job trajectory and life/ job satisfaction of LCP elder care workers.	14 migrant LCP-LTC[1] workers (13 Filipino) in 2009 5 migrant LCP-LTC workers in 2011 before, during, and after working under LCP.	Mixed methods: Face-to-face interviews, job satisfaction scale.	Social isolation Resilience
Kapiga, 2009	Montreal, Quebec	To explore the influence of the LCP on the socio-economic integration and personal experiences of a sample of Filipina live-in caregivers using an anti-racist, feminist approach.	31 Filipina live-in caregiver women.	Qualitative: Semi structured interviews.	Asymmetrical accountability Social isolation Resilience
Miller, 2010	Montreal, Quebec	To explore some of the challenges experienced by Filipina caregivers in the LCP; barriers faced in	15 Filipino LCP caregivers, 3 community organization	Qualitative: In-depth semi-structured	Economic exploitation

[1] Long-term Care (LTC)

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		confronting these challenges; why some caregivers claim their rights; and strategies that migrant caregivers in the LCP use to overcome barriers to accessing rights.	workers and 2 government employees.	interviews between 2009-2010.	Downward occupational mobility Asymmetrical accountability Social isolation Resilience
Oishi, 2008	Toronto, Ontario	To analyze the experiences of migrant elder caregivers under LCP, their working conditions, how they exercise their rights, and the economic integration process after LCP.	40 Filipino migrant care workers, 27 government officials/ recruitment agency representatives/ employers/ NGO[2] representatives.	Qualitative: In-depth interviews between 2005-2007.	Economic exploitation Downward occupation mobility Social isolation
Palmer, 2010	Toronto, Ontario	To understand how Filipina LCP migrants cope with their experiences of exclusion at various scales across Toronto. To explore some of the key sites and spaces of the social networks of Filipina LCP migrants. To enrich the understanding of the global care chains model by drawing attention to the coping practices of Filipina LCP migrants in their efforts to create communities of affirmation, care, and belonging.	30 Filipina LCP migrants for young children.	Qualitative: Semi-structured in-depth interviews and participant observation between February 2009-May 2009.	Social isolation Asymmetrical accountability Resilience
PINAY, 2008	Vancouver, British Columbia	To argue that the LCP sets the course for families' lives in Canada, by drawing all of the family members into its orbit of social exclusion.	27 Filipino families who have lived through the LCP experience.	Qualitative: Interviews between 2004-2008.	Economic exploitation Downward occupational mobility Asymmetrical accountability

[2] Non-Government Organization (NGO)

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Pratt et al. (2009)	Vancouver, British Columbia	To argue that rather than reunification ending the LCP experience, the LCP sets the course for families' lives in Canada, by drawing all of the family members into its orbit of social exclusion	27 Filipino families who have lived through the LCP experience	Qualitative interviews (2004-2008)	Downward occupational mobility Social isolation
Root, 2008	Halifax, Nova Scotia	To explore the lived experiences of domestic workers/ caregivers who live in a small, or medium sized urban centre with lower levels of cultural and racial diversity.	5 Filipino migrant caregivers (3 with children residing in Philippines and 2 single)	Qualitative: In-depth interviews.	Economic exploitation Social isolation
Spitzer, 2009	Rural and small city Alberta	To highlight the experiences of live-in caregivers currently working and living in Alberta outside major urban centres, illuminate the working conditions of migrant caregivers and examine access to social supports or health services.	39 live-in caregivers (38 from Philippines, 1 from India). 224 surveys sent to immigrant serving agencies, extended care facilities, hospitals, religious institutions, service organizations.	Mixed methods. Qualitative: Interviews and focus groups. Quantitative: Survey of local institutions and organizations.	Economic exploitation Downward occupational mobility Social isolation
Tungohan, 2013	Toronto, Ontario	To illustrate how migrant caregivers negotiate their maternal responsibilities from afar and how those responsibilities inform their political activities in Canada.	15 Filipino live-in caregivers.	Qualitative: Semi-structured interviews in 2010.	Social isolation Resilience
Tungohan et al., 2015	Canada (FG: Montreal, Toronto, Ottawa, Calgary, Edmonton, Vancouver)	This study examined the economic, social, and structural barriers involved in the transition from the LCP to the Canadian labour market.	Former live-in caregivers (survey respondents N=631).	Mixed methods: Focus group interviews, national survey data	Economic exploitation Downward occupational mobility Asymmetrical accountability
Banerjee et al., 2017	Canada (FG: Toronto, Montreal, Vancouver, Calgary, Edmonton, Ottawa)	This report summarizes the findings of studies on former LCP caregivers transitioning from the precarious role of temporary foreign workers to permanent Canadian citizens.	Former live-in caregivers (survey respondents N=631).	Mixed methods: Focus group interviews, national survey data	Economic exploitation Downward occupational mobility

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					Asymmetrical accountability Social isolation
Tastsoglou & Dobrowolsky, 2017	Canada (Halifax, Nova Scotia)	This study explored the influence of gender politics on transnational care relations and practices of permanent residents and foreign-born citizens.	Racially diverse newcomers who have been/were involved in transnational caregiving within the last 5 years (N=20; 8 men, 12 women).	Qualitative: Semi-structured in-depth interviews	Asymmetrical accountability Social isolation
Atanackovic & Bourgeault, 2014	Canada (Quebec, Ontario, British Columbia)	This study assessed economic and social integration of live-in caregivers while employed in the LCP, after the 2010 policy changes, and beyond completion of the program.	Current and former migrant care workers involved in older adult care (N=27), child care (N=28), or both (N=3).	Qualitative: In-depth interviews and focus groups	Economic exploitation Downward occupational mobility Asymmetrical accountability Social isolation
Salami, 2014	Canada (Toronto, Ontario)	This study explored the experiences of foreign-trained nurses who migrate to Ontario through the LCP.	Nurses who migrated to Canada through the LCP (N=14).	Qualitative: Case study methodology, in-depth interviews	Downward occupational mobility Social isolation Economic exploitation
Galerand, Gallié, & Gobeil, 2015	Canada	This study explored the effects of exploitative labour laws and conditions faced by caregivers employed through the LCP.	Domestic workers who had been submitted to the live-in requirements during 24 months as provided by the LCP (N=33).	Mixed methods: questionnaire, semi-structured interviews	Economic exploitation Downward occupational mobility Social isolation
Carlos & Wilson, 2018	Canada (Greater Toronto	This study examined the physical and mental health of migrant caregivers employed through the LCP.	Women born in the Phillipines who came to Canada under the LCP	Qualitative: Semi-structured interviews	Asymmetrical accountability

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	Area, Ontario)		(N=23); current live-in caregivers (N=4) and former live-in caregivers (N=17).		Social isolation
Teeple Hopkins, 2016	Canada (Montreal, Quebec)	This study assessed how work intensification, workplace injury, and structural exclusion from labour laws affect paid domestic workers in Canada.	Paid domestic workers, aged 18-65, legally residing in Montreal; migrant live-in caregivers (N=3) or other domestic worker (N=1).	Qualitative: In-depth interviews	Economic exploitation Social isolation
Canay, 2014	Canada (Toronto, Ontario)	This study explored Filipina women's experiences with the LCP in Toronto, Canada.	Individuals with a "live-in" experience under the LCP, who identify as Filipina, age 30-64 years old, have recently completed the program 1-3 years ago (N=3).	Qualitative: Unstructured, open-ended interviews	Economic exploitation Social isolation
Walton-Roberts et al (2012)	Ontario	To examine the experiences of nurses entering Ontario as temporary migrants through LCP and as international students who convert to permanent status and re-enter the nursing profession. What are the pathways (re-training, language training, etc.) these nurses take to gain re-entry into the profession? What are the impacts of this emerging "temp-to-perm" model of migration, on the nursing sector, and on immigrant social and economic integration?	30 Nurses from the Philippines in Ontario under the LCP AND 68 Nurses from India entering Ontario colleges as international students	Qualitative (semi-structured interviews) and quantitative (surveys) 2 sets of case study groups	Downward occupational mobility

  ISSN 2563-9269