Near and Far, with Heart and Hands: The Impact and Value of Carework in the Context of Refugee Policy and Settlement

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Abstract

Canadian immigration policies show clear preference for economic immigration over more care-based immigration programs, such that some immigrants are constructed as contributing to society and others as dependent. Refugee women, who are more likely to be caregivers and less likely to be employed outside the home (Statistics Canada, 2010), are constructed primarily as care receivers. The value of their carework in their homes, in their communities, and transnationally is ignored. The ethics of care framework, together with scholarship emerging on carework, indicate that carework has been unjustly devalued in society. This study examines the intersection of care and Canadian migration policy in the lives of refugee women as they negotiate various caregiving roles. A thematic analysis of in-depth interviews with six women who migrated to Canada as refugees was conducted. These interviews show that refugee women engage in meaningful carework that contributes positively to the lives of those around them, demonstrating their own resiliency and agency. Canadian policies do not adequately recognize the value of care activities, and therefore their contributions go unrecognized and undervalued. If the true benefits and value of care were recognized, this would have an impact on Canadian immigration policy and refugee women, as caregivers, would be recognized as valuable and contributing members of society.

Résumé

Les politiques d'immigration canadiennes démontrent une préférence claire pour l'immigration économique plutôt que pour des programmes d'immigration basés sur le « care », avec le résultat que certains immigrants sont vue comme étant contribuer à la société tandis que d'autres sont dépendants. Les femmes réfugiées, plus souvent des aidantes naturelles et moins souvent employées à l'extérieur du foyer, sont vues principalement comme bénéficiaires de soins. La valeur des soins qu'elles offrent dans leurs foyers, leurs communautés et de façon transnationale n'est pas prise en compte. Le cadre théorique de l'éthique du « care », ensemble avec la littérature émergeante sur le travail du « care », constate que le travail du « care » est injustement dévalorisé dans la société. Cette étude examine l'intersection du « care » avec la politique canadienne de la migration dans les vies de femmes réfugiées qui négocient des rôles d'aidantes variés. Une analyse thématique de six entrevues en profondeur avec des femmes qui ont migré au Canada comme réfugiées a été entreprise. Ces entrevues nous montrent que les femmes réfugiées sont engagées dans du travail du « care » significatif qui contribue de façon positive aux vies de ceux autour d'elles, une signe de leur résilience et leur pouvoir d'agir. Les politiques canadiennes ne reconnaissent pas adéquatement la valeur de ces activités de « care ». Ainsi, leurs contributions restent cachées et sous-valorisées. Si les vraies bénéfices et valeur du « care » étaient reconnues, il y aurait un impact sur la politique canadienne de la migration et les femmes réfugiées, en tant qu'aidantes, seront reconnues comme étant des membres de la société de valeur et faisant une contribution importante.

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1 Introduction

Since the 1980s, an increasing amount of scholarship has evolved around the practice and value of carework, particularly the impact of caregiving roles on the lives of women, families, and communities. Recent scholarship on carework describes the practice of caregiving and points to the devaluation of these practices by society. The devaluation of care predominately affects women, and disproportionately affects minority or low-income women. Immigrant and refugee women are proportionately more likely to hold care-related employment, be responsible for carework done in the home (due to cultural expectations and other factors), and preserve care connections to home communities abroad (CCR, 2004; Hochschild, 2000; Raghuram, 2012; Rousseau, Mekki-Berrada & Moreau, 2001; Service Canada, 2014; Spitzer, et al., 2003; Stewart, et al., 2006; Yeates, 2004). While there exists gender-based analysis of immigration and refugee policies, as well as scholarship on caregiving and carework, there is limited care-based analysis of refugee policy and experience in Canada (CCR, 2004; McMichael & Ahmed, 2003; Rousseau et al., 2001).

This project focuses on the experiences of women who migrated as refugees to Montreal as they negotiate various caregiving roles—in particular, how their experiences of providing care in various settings like home, work, community, and communities abroad impact their lives in Canada, specifically, their migration and settlement experience. In summary, the research questions are as follows:

- How do various caregiving roles and responsibilities impact the lives of women who come to Canada as refugees?
- How does immigration policy shape the way in which refugee women experience caregiving?
- In what ways can value be attributed and recognized in these experiences?

In order to address these questions, scholarship on carework will be examined, as well as Canadian policy and research on refugees and family separation. The ethics of care will be used as a conceptual framework for the thematic analysis of in-depth interviews with six women living in Montreal who came to Canada as refugees who discuss their experiences caring for their immediate family, extended family, and their community, both in Canada and overseas.

It will be demonstrated that Canadian immigration policy indicates a strong preference for economic immigration, setting up a dichotomy under which economic immigrants are understood to be contributing positively to Canada and people migrating under more care-based immigration programs,

such as the refugee and family reunification programs, are constructed as non-contributing and dependent. As such, it will be argued that refugee women, who are more likely to be caregivers and less likely to be employed outside the home (Statistics Canada, 2010), are constructed primarily as care receivers and the value of their carework in their homes, in their communities, and transnationally is ignored. The ethics of care framework, together with the great volume of scholarship emerging on carework, indicate that carework has been unjustly devalued in society. It will be argued that carework is beneficial not only to society at large, but also that being in the role of caregiver is incredibly meaningful and beneficial to those providing care. Finally, it will be argued that if the true benefits and value of care were recognized, this would have an impact on Canadian immigration policy and refugee women, as caregivers, would be recognized as valuable and contributing members of society.

2 Defining the Care Lens

Care is a broad term that encompasses a range of relational and physical interactions, can be located in the familial context, paid labour, and/or in volunteer capacities in the community, and about which much has been theorized in a variety of different fields. The organization of care has evolved according to changing family structures, community ties, and institutional policies. Care is operationalized through the activities of carework, which will be defined as paid or unpaid instances of "looking after the physical, psychological, emotional and developmental needs of one or more people" (Raghuram, 2012, p. 157), both in enacting "instrumental tasks" and through "affective labour" (Valiani, 2009, p. 5). Most often these tasks include minding and nurturing the development of children, responding to the health and day-to-day needs of the elderly or sick, as well as domestic duties like the provision and preparation of food, cleaning, laundering, and more generally, managing the health, education, emotional, and social needs for individuals or communities (Folbre, 2006).

Folbre (2006) defines carework through the criteria of process, outcome, and beneficiaries. Additionally, any definition and discussion of care must include a consideration of who provides care and how this role is structured through social, economic, and political norms. This section will delve into these criteria to understand the lens of care as it is presented through the process of carework and caregiving, the outcomes of carework and caregiving, who the care recipients or beneficiaries of carework generally are, and an in-depth understanding of who provides care or is most likely to take on the role of caregiver. Together these pieces culminate in an understanding of how care is structured in such a way so that it is consistently devalued, with specific emphasis on the Canadian context and immigrant and refugee women.

2.1 Process

Carework requires direct, often personal, relationships and contact with care recipients. A distinction should be made between workers involved in direct carework and those in the care sector who do not provide direct service or have regular interaction with care recipients. Folbre (2012) makes further distinctions between direct carework, or what she labels *interactive care activities*, and other carework characterized through *support care* and *supervisory care*. In contrast to direct or interactive care, which requires contact and interaction with care recipients, support care is defined by "nonnurturant" care

activities, like meal preparation, cleaning, and domestic duties, or administration and management. These are tasks which can be done impersonally, but provide the structure for personal interaction. Supervisory care refers to the state of being available for care activities, or "on-call" for interactive care—for example, supervising a sleeping infant. Though not in itself a care activity, this work is a care necessity that often interrupts or limits other work.

2.1.1 Affective Labour

The personal nature of direct carework gives it the unique designation of *affective labour* (Gutierrez-Rodriguez, 2014). Within paid carework, there is a distinct push for caregivers to build relationships with care recipients. This is heightened by the intimate location within the private households of care recipients where most carework takes place, as well as the frequent and intimate tasks of which the work is comprised (England, 2005; Gutierrez-Rodriguez, 2014). Folbre's definition of care even highlights this aspect, stating that the carework be in some way motivated by genuine concern for the well-being of care recipients (2012). In the case of unpaid carework, this can be seen as a natural extension of family life where *caring about* and *caring for* are perceived as going hand-in-hand; however, it adds an additional dimension to paid carework. This dynamic could also apply to unpaid volunteer carework, where the affective nature of the labour is seen to be worth the personal costs of donating one's time.

This aspect of affective labour or relationship-building sets paid carework apart from other labour sectors. In many instances, the quality of the carework provided is seen as linked to the relationship between caregiver and care recipient—the better the relationship, the better the care. As in-home familial care is upheld as the ideal, typified by the mother-child relationship, any instance of paid care provision should emulate and recreate *motherly love* (Tuominen & Uttal, 1999). This is also cited as a reason for the overrepresentation of women in paid carework, as nurturance and relationship-building are seen as women's qualities and linked to mothering.

Additionally, in paid carework the economic character of the labour contract tends to be undermined by the relational nature of the work. Because the work is organized around intimate relationships, carework carries with it the assumption that it is performed out of love and affection and therefore resists assignment of market value (Tuominen & Uttal, 1999). As cited by England (2005), economists link affective labour to low wages, as employers can fill jobs at lower pay because the relational nature of the work makes it meaningful and satisfying employment. This is a phenomenon Folbre (2001) calls being *a prisoner of love*.[1] Because of relationships between caregivers and care recipients that are developed through the work, caregivers are more likely to stay in a job with low wages, poor working conditions,

1 England (2005) also notes how mothers and other primary caregivers can also become *prisoners of love*. For example, a single mother is unlikely to give up her child if the child's father withholds child support payments or in the face of low social assistance rates; rather, the system takes it for granted that she will care for the child and make it work, regardless of any support she receives.

and labour contract violations (England, 2005; Folbre, 2001; Folbre, 2012; Tuominen & Uttal, 1999). The true value of carework is thus obscured by the affective, relationship-building focus embedded in the work, both in its social perception and in the attachment felt by careworkers themselves.

This is true of both paid and unpaid carework, in the home or another setting. Given that the genuine care relationship nurtured through the process of caregiving as affective labour is promoted as providing the more beneficial care outcome for recipients, it is ironic that this very relationship also serves to undermine the value that the work itself.

2.2 Outcomes

The desired outcomes of carework can be stated generally as positive contributions to the physical, mental, emotional, and/or social well-being of care recipients (Folbre, 2006; Raghuram, 2012).

The Marxist tradition conceptualizes caregiving as *reproductive labour* or *social reproduction*, whose outcomes provide a necessary piece of the broader labour market consisting of productive work. Reproductive labour includes all the activities involved in reproducing and sustaining workers in the productive workforce, as well as society at large (Duffy, Albelda & Hammonds, 2013). This conception of carework provides a framework for understanding care as a valuable activity that contributes to the well-being of society.[2] Socialists and feminists in the 1960s and 70s built on this framework, elaborating on the value of unpaid care and domestic work in the economic system as central to "maintaining and reproducing the basic social and economic well-being of a society" (Duffy et al., 2013, p. 148). These advocates sought to make caregiving visible in the world outside the home (Gutierrez-Rodriguez, 2014; Tuominen & Uttal, 1999). As understood through this framework, women homemakers doing unpaid care and domestic labour within the home are what allow husbands and children to be productive participants in society. As caregiving and domestic labour in the home are not recognized as work, are unpaid, and are undervalued in general, women doing this work are being exploited by the larger market economy invested in the outcome of productive labour (England, 2005). Further, not only does the labour market benefit, but also society as a whole is an indirect beneficiary of care.

An economic analysis describes how the nature of the distribution of the benefits of carework has, in part, led to its devaluation in the market economy (Duffy et al., 2013; England, 2005). England (2005) describes care as a *public good of production*, defined as those goods which "have benefits from which it is impossible to exclude people who do not pay" (p. 385). These benefits, termed *externalities*, reach beyond the individual receiving care to society at large—for example, "a well-educated workforce, healthy and productive adults, security in illness and old age and the general well-being of the population" (Duffy et al., 2013, p. 150). When goods and service have externalities, the market price fails to reflect the true

2 While carework as social reproduction reinforces the value of caregiving, it falls short of articulating the full breadth of carework (Folbre, 2006). For example, the impact of affective labour on careworkers, as well as carework as organized by gender, ethnicity, and socio-economic location, are generally left out of this discussion.

value of what is provided because all those who benefit do not pay; further, because the social return is more significant than the market return, markets tend to undersupply. England (2005) points to these arguments to reinforce the need for state provision and regulation of carework to compensate for its undervaluation on the market and to meet demands.

2.3 Care Recipients

Care recipients fall into two broad categorizations, either dependent or privileged—each of which indicates an aspect of the devaluation of care. Care recipients viewed as dependent are those who cannot meet their own needs due to age, illness, or some other lack of capacity. They are more likely to be viewed as needy, weak, and non-contributing members of society, where contributing means economic contribution. Carework is devalued through this characterization because, while ignoring that every person is a dependent care recipient at some point in their life, the work is directed toward people who are not economically valuable and is therefore also likely to be viewed as not valuable. Conversely, care recipients may also be incredibly privileged—for example, in an economic position to pay someone to do their carework for them. The implication in this dynamic is that if a person has the resources to pay to have carework done for them, they should, as their time could be put to use in other better ways. In this way, carework is also devalued.

2.3.1 Care Recipients as Dependent

Individual care recipients and their families are the most obvious beneficiaries of carework. These care recipients are most often "members of groups that are by normal social standards unable to provide for their own care because of age, disability, or illness" (Duffy et al., 2013, p. 147). Most often this includes children, the elderly, and persons with a disability or illness. As Folbre (2006) notes, care recipients are often those who "lack a political voice" or are otherwise unable to voice their own concerns regarding their care. Additionally, adults may require assistance meeting their care needs due to social location—for example, a recently arrived immigrant may be a care recipient when, due to difficulties with the language or being unaccustomed to a new social service system or culture, a social worker or other advocate accompanies him or her to a medical appointment.[3]

Tronto (1993) describes how, in a society that upholds autonomous and independent individuals as the ideal, acknowledging that everyone has personal care needs at some point during their lives is a threat to this ideal and the power and capability associated with it. As a consequence,

3 Though this type of carework is not always highlighted in the literature, it does fit within the definition of care outlined previously in this study as paid or unpaid instances of "[providing] service to people that helps develop their capabilities" (England, 2005, p. 383), both in enacting "instrumental tasks" and through "affective labour" (Valiani, 2009, p. 5), at the beginning of this section.

> one way in which [society] socially constructs those who need care is to think of them as pitiful because they require help. Furthermore, once care-receivers have become pitiful by this construction, it becomes more difficult for others to acknowledge their needs as needs. This construction further serves to drive distance between the needs of the 'truly needy' and regular people who presume that they have no needs. (Tronto, 1993, p. 120)

Care needs and those who need care are at risk of becoming marginalized, as policy makers and society in general prioritize other issues. Care recipients are often characterized primarily as needy, and their agency and value to society often goes unacknowledged.

2.3.2 Care Recipients as Privileged

In stark contrast to care recipients who are constructed as dependent, many care recipients pay to have care needs met as a mark of privilege (whether intentional or not). Adults who are able to attend to their own care needs also are usually recipients of some form of care, in particular domestic labour. For example, a spouse may benefit from the unpaid domestic and carework of the other spouse, or a person with economic means may hire someone to do domestic labour in their home. The power dynamics involved in this kind of carework, particularly in the context of paid work, are often determined by the social location of the care recipient. Tronto (1993) states the concept of care can help to expose privilege, elaborating how

> [t]he distribution of caring work and who is cared-for serves to maintain and to reinforce patterns of subordination. Those who care are made still less important because their needs are not as important as the needs of those privileged enough to be able to pay others to care for them. (p. 116)

This kind of power structure serves to reinforce the devaluation of carework by characterizing carework as something a person only does if they cannot pay someone else to do it for them.

2.4 Caregivers and Care Structures

Although Folbre does not include a discussion of who provides care in her definition, this is an important facet of understanding carework. Women consistently disproportionately perform carework, whether inside the home or in the context of the labour market; therefore, a lack of social, financial or institutional supports regarding carework disproportionately affects women. Paid careworkers are also often characterized by race, ethnicity and socio-economic opportunities. This section discusses unpaid caregivers in the home and paid careworkers in the labour market, highlighting in both cases

how caregivers come to be characterized by gender and/or race by care policies and the structures of the labour market.

2.4.1 Unpaid Caregivers Structured by Care Policy

The home is a key setting where unpaid caregiving and carework for children, adult dependents, and the family in general takes place. Caregivers in this context have struggled to be recognized as *workers*, due in part to the home primary location of their work (Himmelweit, 1995). Despite efforts of feminist economists in the 1960s to push for domestic duties and in-home familial carework to be recognized as work, it still ceases to have the same recognized value as paid work (Duffy et al., 2013; Lewis, 2006; Himmelweit, 1995). As such, in the tradition of the housewife, this sector of work in the home continues to be designated primarily as a women's responsibility and as *women's work*—an expression of femininity or the character of women, rather than skilled and learned (Duffy et al., 2013). It is also often seen as *invisible work*. Work of unpaid caregivers has been largely undocumented and not accounted for in economics and tabulations of global wealth and resources (Waring, 1999). Further, these workers lack visibility because their work most often takes place in the private sphere of the household.

Women staying in the home to perform domestic duties and caregiving tasks have been long-standing social norms, even with increased involvement of mothers in the labour market. In about half of families with two heterosexual parents in full-time employment, the female partner does the majority of house and carework; in another one third of families, the female partner was considered solely responsible (CRIAW, 2015). These dynamics seem to have remained consistent over time, as estimates from the United States in 2002 indicating that 80% of childcare in the home was done by women (Williams, 2002). Concerning families with children under age fourteen, women spend on average about 50.1 hours per week performing unpaid childcare, doubling the time spent by their male counterparts (24.4 hours) (Statistics Canada, 2010). While average hours vary according to the work status of either parent, in general the distribution remains the same across all work status categories. Similarly, women spend on average double the time per week performing domestic duties compared to men (13.8 hours and 8.3 hours, respectively), as well as more time devoted to the care of a senior family member compared to men (Statistics Canada, 2010).

Over the last four decades there has been a steady increase in women's labour market participation in Canada. Prior to 1961, women's labour market participation was below 30% (Status of Women Canada, 2015). In 1976, of those participating in the labour market, only 37.1% were women; this increased to 47.3% by 2014. In addition to this, there has been a significant rise in the labour market participation of mothers, from 27.6% in 1976 to 64.4% in 2009 of women with children under age three. This represents a significant shift from a time in history when women were primarily engaged in unpaid domestic work caring for their families rather than paid work outside the home; however, the data indicates that

while participation in paid work is today divided much more equally between genders, women are still primarily responsibly for care and domestic work in the home.

These responsibilities have in part been a factor in women's frequent engagement in part-time work (70% of the part-time workforce consistently over the last 30 years). Reports show 13.4% of working women in Canada indicate caring for small children as their primary reason for working part-time, compared to 1.1% of men (Statistics Canada, 2010). Most jobs that include benefits, stable schedules and room for advancement also require full-time employment and do not make room for care responsibilities beyond what is necessitated by provincial legislation. Wages for part-time work often remain lower than those paid for full-time work, and part-time jobs are more often remunerated at minimum wage. Women's overrepresentation in part-time work may help explain why 83% of Canada's minimum wage earners are women and youth (CRIAW, 2015). Even when engaged in full-time work, women with families often experience a "wage penalty for motherhood" (England, 2005, p. 387) when they take leave for childrearing. This time away from work often results in less experience and less seniority when they return, which can be translated into reduced lifetime earnings (CRIAW, 2015).

Familial care responsibilities have significant impacts on the types of work women are most likely to do, and the impact of their labour in sustaining economic security (CRIAW, 2015; Evans, 1998; Townson, 2009). Despite that women in Canada are increasingly engaged in paid labour over the last few decades, the number of women living in poverty has remained high. This prevalence of poverty is especially apparent among 'unattached' women.[4] In 2011, it was estimated that 37% of lone parent female-headed families were living below the Low Income Cut Off (LICO), as well as 34% of unattached women over 65 and 42% of unattached women under 65 (Statistics Canada, 2013). Additionally, 37% of racialized women live below LICO, compared to 19% of all Canadian women (CRIAW, 2015).

As more women caregivers opt to enter the workforce, due to necessity or choice, rather than stay in the home full-time, carework, especially childcare, has become increasing recognized as a fundamental part of the economy (Tuominen, 1994), with care deficits in homes having direct implications on the labour market participation of certain segments of the population.[5] Both public and private systems have developed around this need, though ultimately carework is still most often characterized as a familial responsibility.

Childcare and other family care programs continue to be lacking in the public system, as informal family networks become more strained and women become more involved in the labour market. There was dramatic growth in the formal childcare sector in the 1970s through 1990s (Tuominen, 1994); however, the formal system still largely depends on informal, often familial, arrangements to

4 'Unattached' refers to women's whose martial status is single, widowed or divorced.

5 Families with lower income are more likely to be affected by lack of affordable childcare; additionally single-parent families and families with fewer family or community ties in the area who may be willing to assist with informal childcare.

fill in the gaps. Informal childcare may include relatives, unlicensed centres, and home-based care arrangements. Social policies in various sectors structure a certain care regime that impacts a country's approach to child, senior, and disability care needs. For example, Canada, as well as many European countries, offers cash payments[6] to families in lieu of providing adequate national public childcare services. Policies such as these "encourage the development of a particular form of home-based, often low-paid commodified care or domestic help, generally accessed privately through the market" (Williams, 2011, p. 23). In doing such, demand is created for a certain kind of in-home care provision, and therefore for caregivers willing to do those jobs (Hochschild, 2000). The provision of accessible public care options is cited as a solution that would allow unpaid familial caregivers to balance their care responsibilities with other aspects of their lives, for example their employment; however, equitable care policies have not generally been a popular area of policy development and care is still predominantly seen as a family matter that takes place in the home.

2.4.2 Paid Careworkers Structured by the Labour Market

Caregivers and those doing domestic work, even when performed in the formal care sector as paid work, have suffered from the same stereotypes as unpaid familial caregivers and have been consistently undervalued. Not only does paid carework continue to be structured by gender, but also by race (Duffy et al., 2013). This is made especially evident by immigration programs, like Canada's Caregiver Program recruiting primarily from the global South, and also by the disproportionate number of minority women employed in the care sector. Statistics made available through Service Canada on employment trends in Quebec confirm that paid carework is disproportionately done by female workers, offers low annual income compared to provincial average for all occupations, low levels of full-time/full-year employment stability, and includes relatively high participation by immigrant women in proportion to their percentage of the total Canadian workforce (Service Canada, 2014). Table 2.1 provides statistics for four main categories of carework occupations[7] in Quebec, including proportions of female and immigrant workers as compared to the total working in that occupational category.

These statistics include temporary workers who have come to Canada under the former Live-In Caregiver Program.[8] This program, as well as the more current Caregiver Program (CIC, 2014), provides

6 The Canada Child Tax Benefit and the Universal Child Care Benefit at the federal level are examples of such payments.

7 Other carework categories do exist (e.g. nurses and other health professionals, teachers, and social workers could arguably fit into this category); however, arguably these categories are generally less accessible to immigrants due to complicated processes surrounding credential recognition and gaining adequate professional language skills (Ott, 2013; Service Canada, 2014).

8 Between 1993 and 2009, approximately 52,500 people arrived in Canada as principal applicants of the Live-in Caregiver Program who received permanent residency (Kelly et al., 2011). Nearly all applicants are female and the majority are from the Philippines, with smaller percentages from India and the Caribbean islands—for example, in 2009, 95% were female and 87% were from the Philippines.

Table 2.1 Occupational statistics for carework in Quebec for 2013 (Service Canada, 2014)

Occupation category	*Female workers (%)*	*Immigrant (born outside of Canada) workers (%)*	*Average annual income for full-time/full-year work*	*Workers engaged in full-time/full-year work (%)*
Babysitters, nannies, parents' helpers	96.7%	28.0%	$14,700	34.5%
Visiting homemakers, housekeepers, and related occupations	86.9%	18.0%	$23,000	34.5%
Early childhood educators and assistants	95.9%	14.8%	$22,400	47.0%
Nurses aides, orderlies, and patient Services	81.1%	16.2%	$27,500	42.7%
Community and social service work	75.3%	10.0%	$39,300	52.6%
For all occupations	47.3%	12.2%	$45, 200	53.2%

a route for employers to hire caregivers from abroad while providing a pathway to citizenship for qualified migrant careworkers.[9] A prominent issue characterizing the care sector, especially for positions involving direct care, has been a consistent lack of workers for paid carework positions, giving rise to an influx of recruitment from abroad to fill the carework need in Canada, most notably in the health care, childcare, and elder care sectors. The need for recruitment outside of Canada is indicative of the lack of desirability of these jobs and the poor working conditions of the majority of direct carework positions. Careworkers, especially paid live-in careworkers in private households, are disproportionately vulnerable to a range of exploitative practices and conditions related both to the nature of the work they do and the structures of the immigration programs in Canada (Choudry, Hanley, Jordan, Shragge, & Stiegman, 2009; Hanley, Premji, Lippel, & Messing, 2010; Langevin, 2007; Macklin, 1998; Valiani, 2009). Caregivers are often asked to perform tasks outside of their signed contract, are often expected to work additional hours without overtime pay or other compensation, are paid less than minimum wage, and may experience racial discrimination, verbal abuse, and sexual harassment during their employment (Langevin, 2007; Oxman-Martinez et al., 2004).[10]

Service Canada (2014) statistics do not include workers who are working informally, which could include undocumented or non-permanent residents without a work permit. The number of women in this employment situation is thought to be high, especially since performing carework in private households can be done without regulation (Langevin, 2007). Paid in-home careworkers who lack status

9 The details of this program are outlined in the Immigration and Refugee Protection Regulations (Government of Canada, 2002).

10 Further details on these abuses can be found in a Montreal study of Filipino live-in caregivers conducted by Oxman-Martinez, Hanley and Cheung in 2004, additionally, Choudry et al. (2009) and Hanley et al. (2010).

in Canada are particularly vulnerable to exploitation, as they have little legal recourse for employment problems and risk compromising their livelihood in Canada.

According to Duffy, Albelda, and Hammond (2013), due to its origin in the home as women's work, carework is viewed as fundamentally different from other wage labour, primarily in its relational and nurturing process. Careworkers in these jobs are consistently undervalued because of cultural associations of care and nurturing with women, who have historically been deemed subordinate, as are their stereotypically feminine qualities. Even after controlling for gender, England, Budig, and Folbre (2002) found that jobs requiring nurturing skills suffer a wage penalty. Using data coded for wages, gender, and sector, they argue for the "devaluation thesis" (p. 457). Because carework has traditionally been done by women and women's status has traditionally been subordinate in relation to men, carework has come to also be viewed as a subordinate labour sector, regardless of its actual value and contribution to society. Additionally, carework is also associated with mothering, which is done as an act of love and obligation, rather than for money—an association that has been perpetuated through the low wages of direct carework.

In addition to gender, a similar analysis can be applied using race. England (2005) found that the lowest paid carework jobs are filled predominately by minority women (p. 384). In addition to these analysis, the continuation of these patterns through political, social, and cultural norms, have led scholars to view carework as being primarily structured through gender and race or ethnicity, which has perpetuated the devaluation of caregiving and careworkers (Gutierrez-Rodriguez, 2014; Tuominen, 1994; Tuominen & Uttal, 1999).

3 Refugee Women Settling in Canada

Generally speaking, those arriving to Canada through the refugee stream are the only newcomers whose migration is explicitly involuntary. Given this, refugees often face unique challenges due to conditions in their country of origin and the often unplanned circumstances of their migration (Neupane, 2012; Ott, 2013). Additionally, a gender-based analysis of immigration and settlement issues highlights the unique challenges that women immigrants and refugees face, particularly in relation to the roles and responsibilities in the family, cultural expectations, and lack of programming catered to their specific needs. The intersection of immigration status and gender as experienced by refugee women is a key component in the following research. This section will provide a brief overview of Canada's immigration system, followed by a gender-based analysis of immigration and settlement challenges women commonly encounter when settling in Canada.

3.1 Canada's Immigration System

Canada accepted 24,049 refugees[11] into its borders as permanent residents in 2013 through the refugee stream of immigration laid out by the *Immigration and Refugee Protection Act*, passed in 2002, and reformed in 2012 (CIC, 2013); in addition, 10,350 people claimed refugee status from within Canada or at its borders who may become accepted as refugee permanent residents as their claims are reviewed. The refugee category encompasses 9.3% of all immigrants to Canada that year, with Economic Immigrant being the primary immigration category (57.2%), followed by Family Class immigration (30.8%) (CIC, 2013).[12] Clearly, Canada's immigration system has a strong economic emphasis focused on facilitating the immigration of those who pose the greatest economic benefit to the country. This is evident even in the selection criteria, based on both humanitarian and economic considerations, for care-focused immigration, such as Refugee[13]

11 This number refers to all those who received permanent resident status in 2013, including government-assisted refugees, privately sponsored refugees, refugee claimants whose applications have been accepted (Refugees Landed in Canada), and other refugee dependents.

12 The Humanitarian and Compassionate cases comprise the remaining 2.7% (CIC, 2013). These are applicants who have been determined as failing to meet the requirements of the classification of refugee, but whose return to their country would nonetheless be inhumane as it would significantly endanger their lives. Acceptance of these applicants is less common and this is not generally considered a major stream of immigration.

13 Though the mandate of the Refugee class of immigration is humanitarian, certain economic and integration criteria are often involved in the selection of government-assisted refugees and potential sponsors of privately sponsored refugees.

and Family Class streams. For example, financial criteria for sponsors or estimated ease of integration into Canadian society are examples of economic-focused criteria used in other across all immigration streams, as applicable.

While the policy evolution pertaining to economic immigration has provided more opportunities and a predictable increase in immigration through these programs, policy development pertaining to refugees has made it more difficult to migrate to Canada with refugee status, as evidenced by steady the decline in the number of refugees Canada accepts annually over the last twenty years. In 1990, Canada accepted 40,218 refugees, which dropped to 30,091 by 2000 (CIC, 2013). By 2010, the number had dropped further to 24,697 and has remained on average around 24,000 since, with the majority being from Africa and the Middle East. Of these, 4,200 settled in Quebec in 2013. Currently, of these refugees, approximately half are male and half are female.[14] This is a relatively new occurrence. A gender breakdown of the number of accepted refugees over the last twenty years shows that in previous years, the number of accepted male refugees was consistently higher than the number of females accepted—for example, 24,027 males and 16,191 females in 1990. While the overall number of refugees Canada accepts annually has declined, this is mostly accounted for through the drop of male refugee acceptance by approximately 50%, with relatively minor fluctuations in the number of female refugees accepted over the last twenty years. Of the total number of refugees accepted in 2013, 20.7% were children fourteen years old and younger.

Canada's refugee immigration system consists of two main parts (CIC, 2015). The Refugee and Humanitarian Resettlement Program pertains to those applying from outside of Canada seeking protection, who, if selected, may enter as *government-assisted refugees* or *privately sponsored refugees*. The In-Canada Asylum Program pertains to people making a claim from inside Canada or upon arrival at the border, referred to as *refugee claimants* or *asylum-seekers*. To be accepted into either of these programs, an applicant must fit the definition of a United Nations Convention refugee, a status given to those determined to fit the definition of refugee in accordance with the United Nations' *Convention and Protocol Related to the Status of Refugees* (1951), or a person in need of protection, as outlined in the *Immigration and Refugee Protection Act* (2002). A person may be considered a Convention refugee owing to

> a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion [and] (a) is outside each of their countries of nationality and is unable or, by reason of that fear, unwilling to avail themself of the protection of each of those countries; or (b) not having a country of nationality, is outside the country of their former habitual residence and is unable or, by reason of that fear, unwilling to return to that country. (Government of Canada, 2001, 96)

14 Exact numbers for 2013 show 12,124 males and 11,925 females and a population total of 24,398 (CIC, 2013).

Alternatively, an applicant may be considered a *person in need of protection*, defined as

> [a] person in need of protection is a person in Canada whose removal to their country or countries of nationality or, if they do not have a country of nationality, their country of former habitual residence, would subject them personally to a danger, believed on substantial grounds to exist, of torture… or to a risk to their life or to a risk of cruel and unusual treatment or punishment… (Government of Canada, 2001, 97)

Working with the United Nations, Canada selects refugees in accordance to its own criteria, which includes both humanitarian and economic considerations.[15]

If accepted as a government-assisted refugee, the applicant will enter Canada as a permanent resident with the federal government assuming primary settlement responsibilities. Through the Resettlement Assistance Program, port of entry and reception services, information, orientation, and provisional housing are provided to government-assisted refugees for the first four to six weeks following arrival. According to need, basic income supports, language classes, and other services are also provided through Citizenship and Immigration Canada's Settlement Program to aid government-assisted refugees in their settlement for the first year (CIC, 2015).[16] In 2013, 5,790 people were accepted into Canada as government-assisted refugees (CIC, 2013).

Refugees may also be selected to come to Canada through private sponsorship (CIC, 2015). In this case, sponsors are responsible for the basic settlement needs of those they have sponsored, including housing, food, clothing, and any other financial needs or emotional support for one year.[17] A sponsor may be an incorporated organization that has signed a formal agreement with Citizenship and Immigration Canada to be a sponsor (referred to as a Sponsorship Agreement Holder), a Constituent Group (a group of five or more Canadian citizens over the age of 18 who fit the economic criteria required for sponsorship), or any community organization that meets the economic criteria (CIC, 2015). In 2013, 6,396 people came to Canada as privately sponsored refugees. This was the first time that the number of privately sponsored refugees has exceeded the number of government-sponsored refugees accepted through Canada's immigration system (CIC, 2013).

Additionally, as mentioned above, a person may claim refugee status from within Canada or upon arrival at the Canadian border, which will give them the status of *refugee claimant*. Refugee claimants are permitted to reside in Canada until a decision has been made by the Immigration and Refugee Board of Canada regarding the legitimacy of the claim.[18] If accepted, they are granted permanent residency and are eligible for services under the Settlement Program. When applying for their permanent residency status, claimants

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15 For those settling the Quebec, the province reserves the right to approve applications in accordance to its own additional criteria.

16 This is the general policy, though exceptions may be made according to need.

17 This could be extended to three years in special cases.

18 Recent legislation on the refugee determination process for asylum seekers was implemented in 2012, including the *Protecting Canada's Immigration System Act* and the *Balanced Refugee Reform Act* (CIC, 2015).

may also list immediate family members overseas to be included in the application as dependents. If not accepted, refugee claimants are issued deportation dates and must return to their country of origin or, due to 2012 reforms, they may choose to stay and pursue an appeal of the rejected decision.

Because of their temporary status in Canada, refugee claimants do not have access to the same services and opportunities as permanent residents do, making them particularly vulnerable to income and housing instability, and physical and mental health issues (Morantz, Rousseau, Banerji, Martin & Heymann, 2013; Renaud, Piche & Godin, 2003). For example, while a refugee claimant can acquire a work permit after six months in the country, their temporary Canadian status may be a barrier to obtaining substantial employment; additionally, while they may be eligible to receive social assistance, they are not eligible for all benefits, including Family Benefits like the Quebec Child Assistance Benefit or the Canada Child Tax Benefit. In 2013, 8,149 refugee claimants were accepted to become permanent residents (CIC, 2013). During this year a further 10,350 people filed new refugee claims[19]—the lowest number of claims Canada has seen in the previous 20 years by more than half (CIC, 2013b). This should not be seen as an indication of decreasing global conflict, but rather as a symptom of new Canadian immigration policies implemented in 2012 that have made filing a refugee claim more difficult.[20]

3.2 Settlement Experiences of Immigrant and Refugee Women

Overall higher levels of female migration led the Canadian Council of Refugees (CCR) to implement a gender-based analysis of immigration issues and settlement, in accordance with guidelines developed by Status of Women Canada, in recognition of the different ways migration effects men and women (CCR, 2006). Research has shown that immigrant and refugee women are affected disproportionately by systemic barriers that make access to employment, education, and healthcare more difficult (CCR, 2006; Hill, 2011; Morris, 2001). This becomes especially apparent when examining income and economic security. For example, 23% of all women who immigrated to Canada live on low-income, compared to 16% of Canadian-born women; 42% of female immigrant women with children under age 15 lived in low-income households, compared to 17% of Canadian-born women (Statistics Canada, 2010). Labour force participation rates and economic security vary not only according to gender, but also immigration status. For women immigrating as skilled workers, the labour force participation rate is 91.1%. In contrast, it is 77% for family class, and 63.9% for refugee women (Statistics Canada, 2010). For men immigrants, the labour force participation rate is 90% across all immigration categories. Further, when immigrant women do work, they earn on average $2000 less than Canadian-born women, and $11,000 less than immigrant men (Statistics Canada, 2010).

19 Of these, approximately half are male and half are female (CIC, 2013b).

20 For example, the *Protecting Canada's Immigration System Act* and the *Balanced Refugee Reform Act* (CIC, 2015).

While there are many factors that contribute to these outcomes, of particular relevance to the lives of immigrant and refugee women is a lack of access to affordable childcare and access to services, programs, and opportunities that take into consideration "the reality of women's lives, especially the impact of their domestic and caretaking roles" (Hill, 2011, p. 9). While access to childcare is an important issue for all families in Canada, immigrant and refugee women many be particularly affected by it because they often do not have the same family network available to them to help with caring responsibilities and are unfamiliar with the organization of Canadian caring systems (Hill, 2011; Morantz, et al. (2013); Stewart et al., 2006;). Lack of childcare also has a particular effect on the integration of immigrant and refugee women, who may find themselves particularly isolated in their homes due to caring responsibilities, and unable to participate fully in language-learning classes, other education, or employment (Hill, 2011; Morantz et al., 2013; Stewart et al., 2006).

As shown in a study by Spitzer, Neufeld, Harrison, Hughes and Stewart (2003) looking at the intersection of gender, carework, and migration to Canada in the lives of women immigrating from Chinese East Asia and South Asia, familial caregiving provides a particular challenge for women trying to fulfill cultural expectations in a new social context, with different access to resources, extended family, and other potential helpers who would have shared the workload in their countries of origin. These tensions are even more apparent when coupled with the need for a two wage-earner household, such that the primary caregiver must also work outside the home. While the phenomenon of women being both workers outside the home and also the one primarily responsible for domestic duties and caregiving inside the home is not particular to the migration experience, but rather commonly experienced by many women across Canada, immigrant and refugee women may have a different experience of this double duty due to different cultural pressures. The participants of Spitzer et al.'s study described the difficulties of caregiving in a new context where they have less familial support, pressures to maintain privacy and keep care provision in the family and a lack of culturally appropriate caregiving supports and programs (2003). Many participants came from countries without caregiving support systems, and this unfamiliarity made them less likely to seek these programs out and more wary of trusting them.

While acknowledging the challenges, immigrant women participants identified with the traditional view that women are the most appropriate caregivers for their families and rejected the idea that carework was burdensome. Rather, they viewed it as an honoured responsibility. Participants in this study linked their role as caregiver with the responsibility of maintaining cultural identity and modeling moral virtues in their families. Spitzer et al. (2003) alludes to western cultural constructions of caregiving as burdensome work, and suggests that reforming the appraisal of carework in Canadian society as valuable work may help alleviate the tensions and stress experienced by all caregivers.

4 Family Separation and Caring across Borders

Family separation and the creation of transnational families can be a consequence of all types of migration, which can impact individuals and communities significantly. Current trends show a feminization of migration, wherein mothers are migrating independently for the economic benefit of the family. While employment and educational opportunities are often driving forces behind migration, family separation may also be the result of global economic, political, and social factors, changes in family relationships and policies of receiving countries that produce delays in family reunification processes (Falicov, 2007). Regardless of the reasons, family separation requires changes in the roles, responsibilities, and methods of providing care. Immigration policies that enable family reunification thus have a significant role in influencing the care networks in transnational families in Canada and abroad, affecting all individuals involved. Immigration policy that easily facilitates reuniting family from abroad with their Canadian family members would have a positive impact on the care families are able to provide.

4.1 Global Care Chain

One area receiving increasing attention regarding its effect on family separation is the migration of mothers independent of their families for economic purposes. This area of research has been key to understanding consequences of family separation as felt by primary caregivers, care recipients, and communities, as well as shedding light on the global inequalities imbedded in the circumstances that create transnational families.

As the demand for care labour increases, countries with care regimes relying on market-based care provisions have created policies, for example, Canada's Caregiver Program, that enable a cheap flow of migrant labour to meet the demand. Caregivers and careworkers of various labour sectors are recruited from areas of the world where women have limited economic opportunities in order to work and fill the need for care services in wealthier countries. Scholars studying globalization and migration have noticed growing trends pointing toward the feminization of labour migration, marked most obviously by the movement of women from the global South to households in the global North to perform domestic and carework (Gutierrez-Rodriguez, 2014; Khan, 2009; Macklin, 1998; Razavi, 2007). These labour migration movements are supposed to be mutually beneficial, providing care solutions to wealthy, northern families struggling to meet caregiving demands, as well as economic and immigration opportunities for

women working as migrant caregivers, as in the case of Canada's Caregiver Program. From a feminist perspective, programs designed to promote the transference of care responsibilities from Canadian women to relatively impoverished "women from disadvantaged racial and ethnic groups," should raise questions (Razavi, 2007, p. iii). As Langevin (2007) states, "[B]ringing in underpaid women from disadvantaged countries enables others in industrialized countries to free themselves from household chores, enter the labour market, and achieve a certain degree of economic independence" (p. 199), perpetuating racial, gender, and socio-economic inequalities.

The migration of careworkers is generally determined by the policies of wealthier countries (Williams, 2011). Policies put in place by large transnational institutions, such as the World Bank, the International Monetary Fund (IMF), and the World Trade Organization (WTO) also create conditions in less wealthy countries that necessitate migration out of country to secure work (Meghani & Eckenwiler, 2009). For example, Structural Adjustment Programs, administered by the World Bank and the IMF, force less wealthy nations, particularly in Africa, Asia, Latin American, and the Caribbean, to reduce public spending on health and social programs, public utilities and transportation, and block price controls on basic goods (Meghani & Eckenwiler, 2009). Those citizens most impacted most by these social spending cuts are those with the lowest financial security and the least resources, those who rely most on public programs. Additionally, international free trade agreements under the WTO compel governments of less wealthy countries to eliminate tariffs on imports and cut subsidies for locally-produced goods, destroying local industries, and forcing the unemployed to look outside their country for income (Meghani & Eckenwiler, 2009). While all three of these transnational institutions are technically accessible to all countries, the distribution of representation disproportionately favours countries with the most economic clout. For example, in 2006, the United States held about 16% of the voting rights in the World Bank, Japan held almost 8%, and Germany held 4.5%, each with their own executive director. Comparatively, the majority of Africa shared a single executive director and a combined total of approximately 3.4% of the voting power (Meghani & Eckenwiler, 2009).

Immigration laws in host countries construct the legal, social, and civil rights available to migrants, as well as determining who is allowed to come, how long they are allowed to stay and what they are allowed to do while here (Williams, 2011). Additionally, the specific formulations of a country's care regime influence the child, senior, and disability care needs of its citizens, for example, offering subsidies to pay directly for caregivers in lieu of national public care systems.

Policies such as these are often designed to decrease social expenditures and manage the burden of uncertainty (Marris, 1998). If Canadian families come to see in-home caregiving as the preferable method and privately hiring a caregiver as a viable childcare solution (although for the majority of Canadians this option is completely economically inaccessible, even with the low wages associated with migrant caregiver programs), then the demand for public care system may be curbed and the government will not have to invest in them. Further, the risk of the investment and its outcomes is managed through

the "devolution of responsibility" (Marris, 1998, p. 5) from the public sector to the private sector—often onto the service user (now consumer of care) and those dependent on those jobs.

In determining the impact of care labour migration programs, families and communities that migrant careworkers leave behind have to be included. This analysis is captured by the *global care chain framework* developed by Hochschild (2000). A global chain of care is "a series of personal links between people across the globe based on the paid or unpaid work of caring" (Hochschild, 2000, p. 357). When a mother (or any primary caregiver) from Canada enters into the workforce, the family must find another means to accommodate their care needs—they need to find someone to care for their children, elderly parent or other dependents while they are at work. This person could be a migrant careworker from another country. This person often has care responsibilities in their own family or community in their country of origin that they are leaving behind.[21] She will most likely send remittances home to support her family, which may include wages for another woman she has hired to be a live-in caregiver for her own children. This woman would most likely be from a less privileged part of the migrant caregiver's home country and she may also have care responsibilities in her own home, which perhaps a elder daughter will stay home to perform. At each link in the chain, there is an identified care deficit that is filled by the caring labour of another woman who is generally socio-economically less privileged (Hochschild, 2000; Yeates, 2004). This chain may take many different forms: it may begin and end in the same country, moving from rural to urban or across socio-economic classes, or it may extend across several different countries; it may be entirely commodified, or it may rely on various familial connections (Hochschild, 2000; Yeates, 2004).

The global care chain provides a framework for understanding the development of the international care economy, whereby exchanges are structured through social-economic class, race, and gender (Hochschild, 2000; Razavi, 2007; Yeates, 2004). As Yeates (2004) elaborates,

> Global care chains do more than demonstrate the connections between personal lives and global politics; they elucidate the structures and processes that reflect and perpetuate the unequal distribution of resources globally. Global care chains reflect a basic inequality of access to material resources arising from unequal development globally but they also reinforce global inequalities by redistributing care resources, partially emotional care labour, from those in poorer countries for consumption by those in richer ones. (p. 373)

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21 For example, data from the Philippines shows a clear trend of the increased participation of women in migratory labour abroad. In 1975, it was estimated that 12% of migrant Filipino workers were women; by 1985 this number had rose to 47% (IBON Foundation, 1999). This increase coincides with the Filipino government's increased focus on labour migration and a tapering off of a construction boom in the Middle East during the 1970s that provided work for many male Filipino migrant workers. The increase in women's participation continued—in 1995 up to 58% of migrant Filipino workers were women, and by 2005, they comprised 72% of the migrant Filipino workforce (Scalabrini Migration Centre, 2011). The majority of women who do migrant labour are single; however, there has also been a considerable increase in the number of married women (and presumably therefore women with children) participating. The POEA reports that, in 1993, 15.7% of migrant women were married, and by 2009 this number had increased to 37.3%.

Hochschild (2002) also speaks of "love as an unfairly distributed resource—extracted from one place and enjoyed somewhere else" (p. 22). Ultimately, this illustrates how care has become commodified, such that it is possible to refer to care surpluses in wealthy countries (where children benefit from the care, love, and attention of parents as well as hired caregivers) and care deficits in less wealthy countries (where children experience the absence of their primary caregiver who is overseas caring for others).[22] The framework demonstrates that in this international economy of care, even receiving the care of one's own parent has become a privilege.

There have been several critiques of Hochschild's articulation of global care chains. In particular, Yeates (2004) states that the framework has been applied too narrowly. Hochschild's uses the framework primarily in reference to women as domestic workers and in-home child careworkers coming from the global South to work in the global North for other women. Yeates calls for the broadening of global care chain analysis to include "an expanded range of services within the care sector as a whole" (p. 374). This expansion could include (1) an analysis of skill levels and occupational hierarchies, (2) an analysis of different family types and configurations, (3) the inclusion of careworkers in institutional settings, (4) the inclusion of different care sectors, including health, education, and sexual services, and (5) the location of current trends within historical contexts. This expansion could include instances of transnationally displaced care that are not labour-based yet nonetheless are the result of global forces, such as family separation due to conflict. The global chain of care framework, while typically applied to female migrant careworkers, can also be applied to experiences of newcomer women, in general, and more specifically of refugee women who become displaced caregivers when their families and communities are torn apart due to war and other crises.

4.2 Transnational Families

Family separation may include the splitting up of nuclear families, wherein one or both parents, or children, migrate independently of each other with the intent of reunification at a later date. It also includes instances where a single family unit migrates away from extended family. In either case, family separation requires family structures and dynamics to adjust to new configurations of care and responsibility. For example, grandparents may assume care responsibility for children whose parents have migrated and send financial support through remittances.[23]

22 There is an increasing amount of scholarship being devoted to the impacts on children whose mothers migrate. Hochschild (2002) refers to data from the Scalabrini Migration Centre in the Philippines, where an estimated 30% of Filipino children have a parent involved in migrant labour overseas, indicating profound negative effects on children, especially in relation to health and mental health outcomes. More recent studies from the Philippines reveal a more nuanced understanding, with outcomes primarily determined by the quality of parent-child relationships prior to migration and the quality of the family supports the child is surround by while their parent is away (Scalabrini Migration Centre, 2011).

23 This is a common care configuration among transnational families—see Salazar Parrenas (2002) for a study of Filipina mothers who have migrated as careworkers, as well Falicov (2007) and Bernhard et al. (2005) for there respective studies with Latin American mothers migrating for economic reasons and their experiences in transnational families.

As Bernhard, Landolt, and Goldring (2005) discuss while introducing their study of Latin American mothers in Toronto who experienced separation from their children, family separation is not something families do because they see it as a "desirable strategy" (p. 2); rather, maintaining a transnational family is a difficult endeavour that requires as enormous amount of carework from multiple families members, often carrying with it many invisible social and emotional costs. Mothers in this study report feeling social disapproval and stigma from their home communities for leaving their children in the care of others and transgressing social norms relating to the status and duties of motherhood. Mothers report the personal emotional costs of this separation, the majority of whom cite feeling "constantly sad" as they struggle to maintain the connection with their children, feeling they have deprived their children of something that cannot be replaced (Bernhard et al., 2005, p. 14). These temporary separations often lasted longer than expected, leading to permanent family reconfigurations and relationship and responsibility shifts. These findings are very similar to what Salazar Parrenas (2002) reports in her study involving Filipina women who migrate to do caregiving and domestic work abroad. Mothers in this study also struggled with the gendered social expectation regarding motherhood and intense sadness at the prolonged separation from their children and family.

The impacts of family separation in the context of refugee migration are exacerbated in the aftermath of traumatic experiences and concern for the safety of family members left in danger zones (CCR, 2004; Rousseau, Mekki-Berrada, & Moreau, 2001). In their study of African and Latin American refugees settled in Montreal, Rousseau et al. (2001) found that 68% of their 113 participants who had not been accompanied by immediate family on arrival were still separated from all or some of them, with an average length of separation of 3.5 years. Separation from extended family was also had a significant impact on many participants. Family separation and waiting for reunification is a source of constant worry, as participants expressed guilt at leaving loved ones behind and fear for the safety of those family members. Refugees living with traumatic memories experience family separation as a link to a certain place or time, reliving experiences associated with news or lack of news from their home country. Rousseau et al. (2001) were specifically looking at the relationship between family separation and trauma resilience, noting the protective effect commonly associated with the presence of immediate or extended family, as well as social group, for those coping with trauma. Their findings show that the impact of family presence varies according to the type of trauma a person has experienced, sometimes their presence "triggers emotional reactions and obligations" or "[on] the other hand, the presence of family members sometimes seems to transform adversity into a source of strength, perhaps by aiding in the rebuilding of a meaningful universe" (Rousseau et al., 2001, p. 57).

Other studies, like McMichael and Ahmed (2003), whose research focused on Somali women refugees settling in Australia and family separation, make connections between family separation, settlement experiences, and personal well-being for refugees. Specifically, McMichael and Ahmed (2003) found links between mental health, or symptoms of emotional distress, and family separation. They

state that the "women's accounts of loneliness and depression centre around disruptions of belonging; finding oneself outside a world of meaningful social networks involving family ties, compassion and exchange" (2003, p. 147), arguing that too often constructions of mental health fail to account for the nuances of these community and family networks. This research further supports the claim that family separation can be especially difficult for women refugees who, due to the abrupt nature of war and refugee displacement, find themselves isolated trying to care for their families without their family network, in a way that they never could have planned for.

4.3 Policy Challenges for Family Reunification

It is clear that family separation is a consequence of migration that many people have to cope with, regardless of their reasons for migrating or immigration status. However, often immigration policies that facilitate family reunification in receiving countries, like Canada, do so in a way that is much more inaccessible for certain groups of people, particularly those with less income. Whether family separation entails a separation between children and parents, or a single family unit and their extended family who were previously caregivers to their children, it can have a significant impact on family caregiving to the extent that family reunification policy, in addition to immigration policy, may also fall under the auspices of family or care policy. Canada's family reunification policies have both facilitated the reunification of transnational families and provided significant barriers for other transnational families. This section specifically outlines Canada's reunification policies and potential challenges.

Shifts in Canada's immigration policies have resulted in increased difficulties in the family reunification process. Since the 1990s, Canadian immigration policy has shifted from family-focused immigration and long-term settlement to an economic focus facilitating the entry of high-level business professionals and, more recently, temporary foreign workers (Bernhard et al. 2005; Bernhard et al. 2009; CCR, 2004; Neborak, 2013). The implementation of the *Immigration and Refugee Protection Act* in 2002 included changes to the refugee determination process and family sponsorship provisions justified as security measures aimed to keeping criminals and undocumented immigrants out, as well as expanding the range of economic immigration programs. Recent changes in 2013 align the Family Class stream of immigration with the economic outcomes and motivations present throughout the *Immigration and Refugee Protection Act*. The Canadian immigration system's "narrow focus on economic outcomes systematically devalues the place that the family unit has historically held in Canada and creates a host of systematic barriers that render family reunification inaccessible to many" (Neborak, 2013, p. 8).

Currently, under the *Immigration and Refugee Protection Act*, it is possible for refugees accepted as permanent residents to include spouses and children living outside of Canada on their applications (CCR, 2004; CIC, 2013c). These applications must be submitted within one year of permanent

residency approval of the principal applicant and include costly processing fees.[24] Family members overseas are subject to medical examinations and security checks, as well as providing proof of the legal relationship with the approved refugee (CIC, 2013c).

The other family reunification stream available to Canadian citizens and permanent residents over the age of 18 to sponsor certain family members to immigrate to Canada is the Family Class stream (CIC, 2014b). Family members eligible for immigration under this program are limited to a spouse, a common-law or conjugal partner, including both opposite- and same-sex partnerships, and dependent children under the age of 18, including both biological and adopted children.[25] Special considerations are also made in the case of orphaned relatives under 18 years old and in the case when a potential applicant has no living relative eligible to be sponsored under the regular provision and no relative already living in Canada as a citizen or permanent resident. In addition to age and legal status requirements, a future sponsor is subject to further eligibility requirements. These requirements include meeting a certain minimum income threshold meant to demonstrate a sponsor is able to meet the basic needs of their family without any financial assistance from the government, excluding cases of disability. The sponsor is also legally obligated to financially support sponsored family members in the Family Class for their first 10 years in Canada. Sponsored family members may not benefit from government financial support during this time. If a person has defaulted on other government loans or legal agreements, they may not be eligible to sponsor family members. Additionally, incarceration or certain criminal offences will also affect their eligibility.

Although Citizenship and Immigration Canada has referred to the family reunification process as streamlined and efficient, especially with its more recent modifications (CIC News, 2013), their statistics reveal increasingly lengthy processing times. In a recent report calling for expedited entry for children separated from parents, the Canadian Council for Refugees (2015) provides analysis of Citizenship and Immigration Canada statistics from 2009 to 2013, showing that, due to immigration processing times, children often wait over two years to be reunited with parents who are already in Canada.[26] Family members of refugees experience the lengthiest processing times, averaging 31 months. Further, when processing times are broken down according to geographical location of the sponsored family member, applications from Africa and the Middle East take on average ten months longer to process than those from Europe.

As reported by the Canadian Council for Refugees (2004), there are numerous reasons for these delays. Establishing family relationship to the satisfaction of immigration officials causes significant

24 Currently, these processing fees are $550 per adult and $150 per child (CIC, 2015c).

25 Prior to 2014, the maximum age of eligibility for a dependent to be sponsored was 22. Recent amendments change the maximum to age 18 (CIC, 2014b).

26 The CCR (2015) is calling for an Express Entry policy for family reunification of parents and dependent children, which would see families reunited within six months; similar to the Express Entry program available to economic immigrants with valid job offers who are promised an application processing time of a maximum of six months.

delays when refugees are unable to provide birth or marriage certificates as documentation of their familial relationship. These documents are often not available as they may have been destroyed or left behind in the aftermath of war or withheld by the refugee's home country's government as a form of persecution or simply not available due to lack of government record-keeping. In these cases, immigration officials request DNA tests. The refugee family is responsible for the cost of these tests, which varies according to country, but averages approximately $300 per person (CCR, 2004). Refugees have also commonly reported having communication issues with Citizenship and Immigration Canada—for example, being asked for documents not applicable to their case and lack of follow-up if their case has been flagged for further investigation. Canadian Council for Refugees reports that refugees turn to their Members of Parliament when they are unable to get information from Citizenship and Immigration Canada—for example, in 2004, Members of Parliament reported that their staffs spend 70–80% of their time addressing immigration inquiries (CCR). The impact of these delays is felt heavily by refugee families in Canada and their family members stranded abroad. Families in Canada feel enormous emotional distress due to concern for the safety of their family members, compiled with the stress of resettlement and effects of trauma (CCR, 2004; Rousseau et al., 2001). This wait time also damages the quality of the familial relationships, as family members overseas start to doubt the intentions of their family in Canada, marriages break up and children feel abandoned. Additionally, the Canadian Council for Refugees (2004) found that when the applications are finally processed and those family members are able to come to Canada, they are often in need of more services upon arrival than they would have been if they had not been left overseas in danger for so long, with little access to health care or education.

Another feature of Canadian family reunification policy is the Parents and Grandparents Program. As of 2011, the Program was put on hold and no new applications were accepted, as Citizenship and Immigration Canada dealt with a significant backlog of applications (CIC News, 2013; Neborak, 2013). Changes to the program took effect in 2014, most significantly setting a quota of only processing 5,000 applications per year. Other significant changes concern the eligibility of a prospective sponsor. In order to sponsor a parent or grandparent, sponsors must show three years of income history, as evidenced by their Canada Revenue Agency documents, which must meet or exceed a minimum annual income that is now 30% higher than the previously required minimum (Neborak, 2013). Additionally, when sponsoring a parent or grandparent, sponsors are responsible for the financial support of these family members for 20 years, as opposed to the previous length of ten years, which still holds for the regular Family Class category. To divert the high demand for sponsorship of parents and grandparents, these family members are encouraged to apply to the Super Visa program, now a permanent fixture in Canada's immigration system (CIC, 2014b; Neborak, 2013). This allows for parents and grandparents to hold a temporary visa to Canada for two years, renewable up to ten years. These visas have a distribution rate of approximately 1000 per month and a high acceptance rate (85% for parents and

99% for grandparents); however, a geographical breakdown of applicants shows substantially lower acceptance rates for applicants from Africa, Asia, and the Middle East, in comparison to those from the United States and Europe.

Because of the criteria requiring sponsors to have higher and more consistent incomes, and take on increased financial responsibility for their sponsored parents or grandparents, or alternatively, to pay the high fees and airfare required by the Super Visa program every two years, low-income families are effectively barred from either of these programs. Extended family models that include a key familial role for grandparents and other relatives are common around the world. In many families, grandparents provide domestic and childcare support, emotional support, financial support, contribute to the socialization of children and act as important transmitters of cultural and linguistic traditions and identity (Neborak, 2013). While it seems clear that this policy is constructed to prevent increased public spending on the financial or medical support of elderly immigrants as care recipients, it neglects their often integral role in many families as caregivers.

5 Reflections on the Literature

The literature on care establishes carework as consistently undervalued both economically and socially, whether unpaid in the home or as paid work in the labour market. This devaluation has been linked to the process of carework as involving affective labour, the outcomes of carework as being public goods and the gendered and/or racialized character of caregivers, especially as it related to unpaid mothering in the home. The literature on care emphasizes caregiving in its relation to the labour market and migration, providing a distinctly economic perspective on assigning value. When refugee families migrate, it is not for explicitly economic purposes; however, for refugees, and especially refugee women, this migration significantly alters the way in which they care for their families and care in their communities. The care lens can be applied more broadly than the simple economic analysis of carework as paid or unpaid to encompass a more comprehensive application of the concept of care, including balancing various caring responsibilities.

Further, the way carework is characterized in the literature contributes to its devaluation, as it is often constructed as a burdensome activity or an obligation that holds women back. While it is clear that carework is challenging and gendered expectations surrounding caregiving have had many negative impacts on the lives of women, this characterization often fails to capture how carework contributes positively to women's lives, as well. There is a need for scholarship that, in addition to acknowledging the difficulties women face when involved in carework, also explores how this work creates meaning for individuals, family networks and communities, and at the same time demonstrates the value of carework in multiple contexts as a public good or component of the social economy.

Immigrant and refugee women face unique experiences in carework compared to caregivers who have not experienced migration. In many cases their migration has meant separation from certain family members, some of who are care recipients (as in the case of separation from children or elderly parents) and others with whom they have shared caregiving responsibilities. As well, the literature has demonstrated how caregiving norms and the nature of carework are in many ways culturally structured; therefore, migration for those with care responsibilities also means adjusting to new caregiving norms and public or community care structures while trying to maintain their own cultural values. Refugee caregivers face additional challenges, as their migration is often sudden and more likely to be associated with traumatic events, with less time to plan for contingencies and changes to family dynamics, and more challenges in family reunification. In addition, refugee women in Canada are more likely to

face difficulties finding employment and more likely to have low-income status. Despite these obvious differences, it is difficult to find literature that speaks solely to the refugee experience of caregiving and family separation. Refugee women are often included together with other immigrants and visible minorities, including economic immigrants or newcomers here specifically to work.

This research will address these gaps by providing an analysis of carework that extends beyond conventional economic conceptualization, to explore how care contributes to meaning-making in the lives of refugee caregivers and the social value it adds to refugee communities. Canadian immigration policy not only needs to ask how migration will enhance the Canadian workforce, but also the social environment, community, and lives of individuals. Refugee women who may have difficulty fully participating in the workforce still undoubtedly contribute to society in other equally valuable ways.

6 Conceptual Framework

The literature presented here has focused on theoretical conceptualizations of care and carework, gender-based analysis of settlement for refugee women in Canada and transnational family caregiving. This section will introduce the ethics of care as the conceptual framework that will be used to aid in analyzing these gaps and the ways in which this project addresses them and uncovers more questions.

6.1 Ethics of Care

The theoretical framework of the ethics of care provides the concepts for analysis and exploration of this topic. While the literature previous presented focuses on the practice of carework, care ethics provides a way to evaluate its value in a way that goes beyond economic considerations. The ethics of care is a feminist moral theory developed in the 1980s by feminist philosophers who were critical of the patriarchy evident in pervading moral theories. Care theorists see *caring for* and *being cared for* as key human experiences that highlight human interaction and interdependence in such a way that it elevates care to a key moral concept (Held, 2005; Tronto, 1993). As defined by Held (2005), the ethics of care consists of five prominent features. The central focus of the ethics of care is the moral importance of attending to the care needs of those for whom one takes responsibility. Other key features include: respect for the epistemic value of emotions like empathy and sensitivity; rejection of the idea that abstract reasoning is always the best approach to addressing moral problems; the need to re-conceptualize the distinction between private and public spaces; and, a relational understanding of personhood (Held, 2005).

While often contrasted with moral theories centred on the concept of justice, modern care scholars have affirmed that the "ethics of care must also concern itself with the justice (or lack of it) of the ways the tasks of caring are distributed in society" (Held, 2005, p. 16). As in the previously presented literature, caregiving extends beyond individual interactions and offers a model and moral imperative for all human relations within a society and globally, for both genders. Tronto (1993) refers to care as a political ideal, advocating for the meeting of care needs as "the highest social goal" (p. 175). As Held (2005) argues,

> We see the deficiencies of the contractual model of human relations within the household, we can see them also in the world beyond and begin to think about how society should be reorga-

> nized to be hospitable to care, rather than continuing to marginalize it. We can see how not only does every domain of society need transformation in light of the values of care but so would the relations between such domains if we took care seriously, as care would move to the center of our attention and become a primary concern of society. Instead of a society dominated by conflict restrained by law and preoccupied with economic gain, we might have a society that saw as its most important task the flourishing of children and the development of caring relations, not only in personal contexts but among citizens and using governmental institutions. We would see that instead of abandoning culture to the dictates of the marketplace, we should make it possible for culture to develop in ways best able to enlighten and enrich human life. (p. 18)

The ethics of care provides a framework through which to assign value to carework in a way that extends beyond common economic considerations, understanding carework as a moral activity with social and political value. The value of care is understood as being necessarily linked to the interdependence of all members of society and the relational nature of personhood. For refugee women, the relationships are often complex, perhaps extending across border and cultures, influencing the way they practice and value their own carework, and the way in which it is situated in their community, society, and across the globe.

This research focuses on how various caregiving roles impact the lives of refugee women, in particular their experiences of migration and settlement and also aims to uncover ways in which value can be attributed and recognized in these experiences. The ethics of care establishes within its framework the value of care and provides an excellent basis for exploring this topic. Because carework is structured as undervalued and unrecognised work, and current social policies consistently value economic priorities over care priorities, caregivers who contribute greatly to their families, communities, and society at large are undervalued and de-prioritised. Care ethics gives a framework for arguing the importance of their work and need for it to be recognized. In prioritizing care, the amount of effort that goes into carework and the contributions of this work are uncovered, and therefore provide a basis for understanding the impact and looking for value. By providing a framework that emphasises care, it becomes clearer that certain social policies do not value care—for example, in the previous discussion regarding economic immigration as compared to care immigration in Canada. Further, care ethics elevates care to a moral and political (Tronto, 1993) imperative, that to not address this inequality would be a moral and political injustice.

7 Methodology

The research questions selected for this study include examining the various caregiving roles and responsibilities impacting the lives of refugee women in Montreal, as well as how these caregiving experiences are shaped by Canadian immigration policies and the social value placed on care. These questions are examined through a qualitative study using in-depth interviews with a small number of participants that will be analyzed thematically to get an understanding of their "lived experiences" of the phenomena of caregiving (Creswell, 2006, p.57). McGill University's Research Ethics Board granted approval for this study. The following section will provide a description of the process of data collection, the thematic analysis, and a discussion of the limitations of this study.

7.1 Data Collection

A total of six women were recruited to participate in this study. Community organizations, care-work facilities/programs, and training programs were contacted via email and telephone regarding the project. These organizations were sent an introductory letter that outlined the purposes of the project and a request to post flyers advertising the need for participants within their organization. The flyer provided a description of the project, intended impacts and necessary contact information. Most participants were recruited with help from the staff from community organizations who were able to identify members who might be interested in the project.

The interviews took place in locations chosen by the participants. Most often the community organizations through which they had heard about the project were identified as safe spaces and were willing to provide a room for the interviews. Other participants chose to hold the interviews in coffee shops that were easily accessible to them. Honoraria to cover the costs of transportation were provided through the author's personal funds to each participant. Three of the six interviews were conducted with the help of translators, who were identified by participants as trustworthy community members or staff from their community organization. Honoraria from the author's personal funds were offered to translators, as well. Participants with young children were encouraged to bring them along.

Upon meeting for the interview, the details and potential impacts of the project were once again reviewed and all outstanding concerns were addressed. Two plain language consent forms

were presented to each participant, and the role of the consent form and Research Ethics Board were explained. The consent form was reviewed with participants and they were each provided with a copy of the form for their own future reference. Special attention was given to sections on confidentiality and permission to be audio-recorded. In two cases, participants preferred not be recorded, and notes were taken during the interview instead.

The interviews were semi-structured and conducted using an interview guide to direct the interview, but participants were also be encouraged to talk at length on their experiences as related to the questions and topics. All of the interviews lasted between one to two hours. Participants were assured that they need not respond to any question or line of questioning with which they were not comfortable, and they could choose to stop the interview altogether at any point. If the participant was unsettled by any part of the interview process, community organization staff members were available to aid in the debriefing process for interviews held in their respective organizations and other referrals were prepared for interviews in alternate locations; however, no special debriefing was requested by any of the participants. These interviews were then transcribed and used as the primary data source for this project.

7.2 Thematic Analysis

Thematic analysis is a method of qualitative research in which the data is organized according to broad themes, "which capture something important in relation to the research question" (Braun & Clarke, 2006, p. 79) so that patterns may be identified and analyzed. The coding process should reflect the full scope of the data and be inclusive and comprehensive (Braun & Clarke, 2006). Inductive semantic analysis was used to analyze data in this project; as such, themes were identified based on explicit textual meaning without trying to fit the data into a pre-existing theoretical framework or code frame. The analytic process marks a progression from description to interpretation, where patterns are identified and linked to broader meanings (Braun & Clarke, 2006). The use of thematic analysis in this study was deemed appropriate as it "provides a flexible and useful research tool, which can provide a rich and detailed, yet complex, account of data" (Braun & Clarke, 2006, p. 78).

Transcripts and interview notes were analyzed using NVIVO coding software. Codes and memo writing were used to try pull out common themes across interviews (Padgett, 2008). Data was first coded broadly along themes that corresponded with care setting—for example, in the home, in the community, transnational—and type of care relationship—for example, familial care and community care, caregiver or care recipient. From there, patterns were identified within these broad themes, and coded accordingly. Particular attention was given to the impact of caring relationships in the narratives as presenting either a benefit or challenge (or both) in the women's lives. Examples of codes that emerged for care benefits included: resilience, meaningfulness, and giving back. Examples of codes for care challenges included separation, helplessness, and loneliness. The final project includes an analysis

of these codes as well as references to the narratives of each participant. Data was also be linked to current trends in carework and settlement concerns for refugee women in Canada using the theoretical framework provided by the ethic of care.

Strategies for rigor were implemented to the extent possible within the context of a one-year MSW program. Extensive debriefing was conducted with the MSW supervisor, an expert in the field of immigration studies and with a long history of working with immigrants and refugees in Montreal. Member-checking, to ensure an accurate understanding of the narratives and the appropriateness of the themes and codes, was possible with two of the six women interviewed (Padgett, 2008). Feedback was given during one in-person follow-up meeting and via telephone. All research tools, codes, and analyses were kept on file to be reviewed, if necessary. Additionally, all but one of the women interviewed had children and a spouse whom they were caring for in their homes. This woman (Ms. S) provided a negative case study, through which it was possible to relate how in-home familial caregiving in particular effects the lives of these women refugees, and also how pervasive and important care relationships can be even apart from its quintessential representation as in-home familial caregiving.

7.3 Limitations

The purpose of this study is to explore the phenomenon of caregiving or carework through the personal narratives of refugee women living in Montreal. As such, in-depth interviews with a small sample of participants was deemed appropriate. This sample size does, however, present considerable limitations on the generalizability of the research. Additionally, due to the method of recruitment and the small sample size, efforts to secure confidentiality have meant that a lot of personal details from certain stories have not been included, or have been included in the most general way possible. Most significantly, this has meant that an in-depth discussion of culture and caregiving has not been included.

All participants were asked and consented to being contacted for the purposes of follow-up. Primarily due to geographical and linguistic barriers, only two participants were successfully contacted for member-checking. To increase the transparency of the research process, all documents used for data-collection purposes are attached as appendices.

8 Profiles

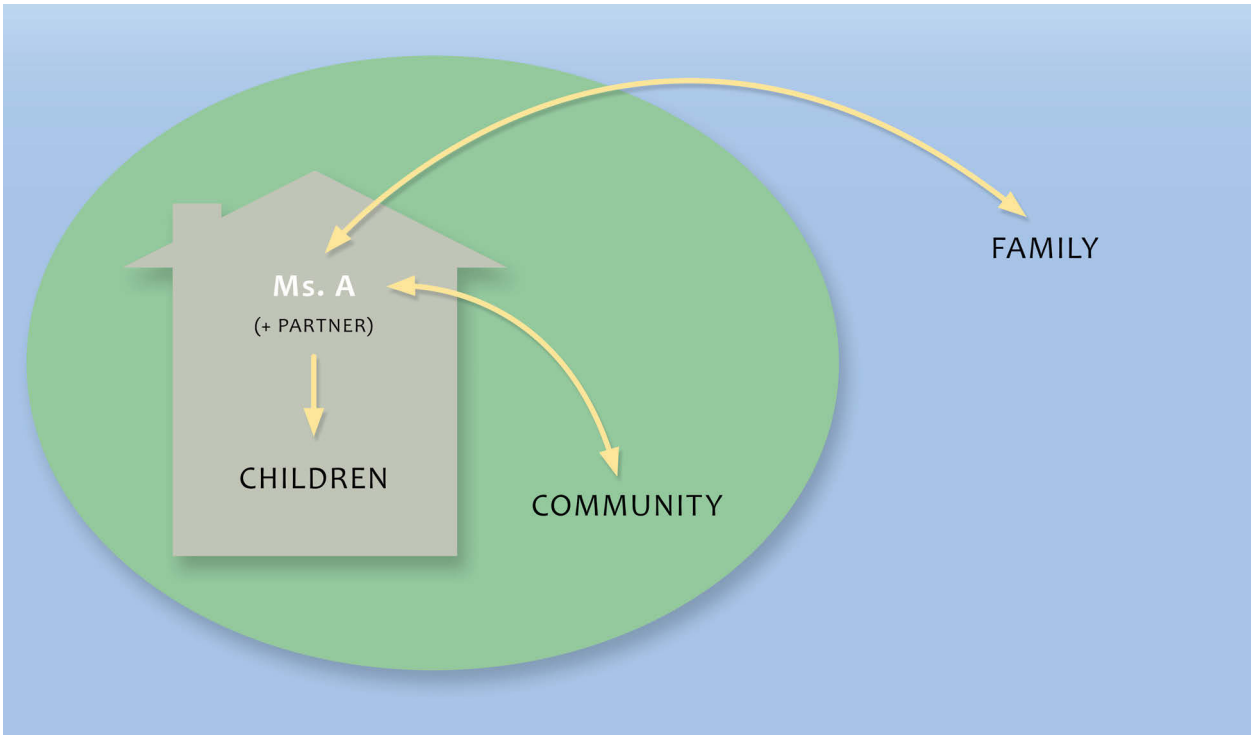
Six women who came to Canada with refugee status or who applied for refugee status in Canada were interviewed for this study. They ranged in age between 30 and 60, with home countries in the areas of South Asia, the Middle East, and Latin America. The following profiles provide synopses of their stories and describe their care responsibilities, which are also featured in diagrams illustrating their various care relationships. The stories shared by participants represent very different perspectives and life circumstances that influence their experiences of caregiving. Each story serves to highlight the diverse and complex ways refugee women's lives can be impacted by caring responsibilities.

Each of the diagrams illustrates personal care relationships as they were described by each participant directly following their migration to Canada or during the early stages of settlement. The diagrams illustrate care relationships within three spheres: the home (as represented by the house), the local community (as represented by the circle), and transnationally (as represented by the rectangle). These relationships consist of either one-way caring relationships, where one party is obviously the caregiver and one party the care recipient, as shown by the direction of the arrow, or reciprocal care relationships, where each party engages in caregiving and receiving, as shown by a two-directional arrow. The relationships connect each participant with her children, her community, or her family. The term *children/child* refers to dependent children, unless otherwise noted. The term *family* may include parents, siblings, and extended family. And lastly, the term *community* encompasses community organizations, places of worship, and informal social networks.

8.1 Profile: Ms. A

Ms. A fled her home country over 15 years ago to a second safe country with her husband and children. From there she and her family were accepted to come to Canada as refugees and now have Canadian citizenship. She currently cares for her young adult children in her home and volunteers for a women's community organization that she regularly attends. She keeps in regular contact with her family still overseas, but her application to sponsor her parents was denied. Currently her sisters overseas are caring for her aging parents.

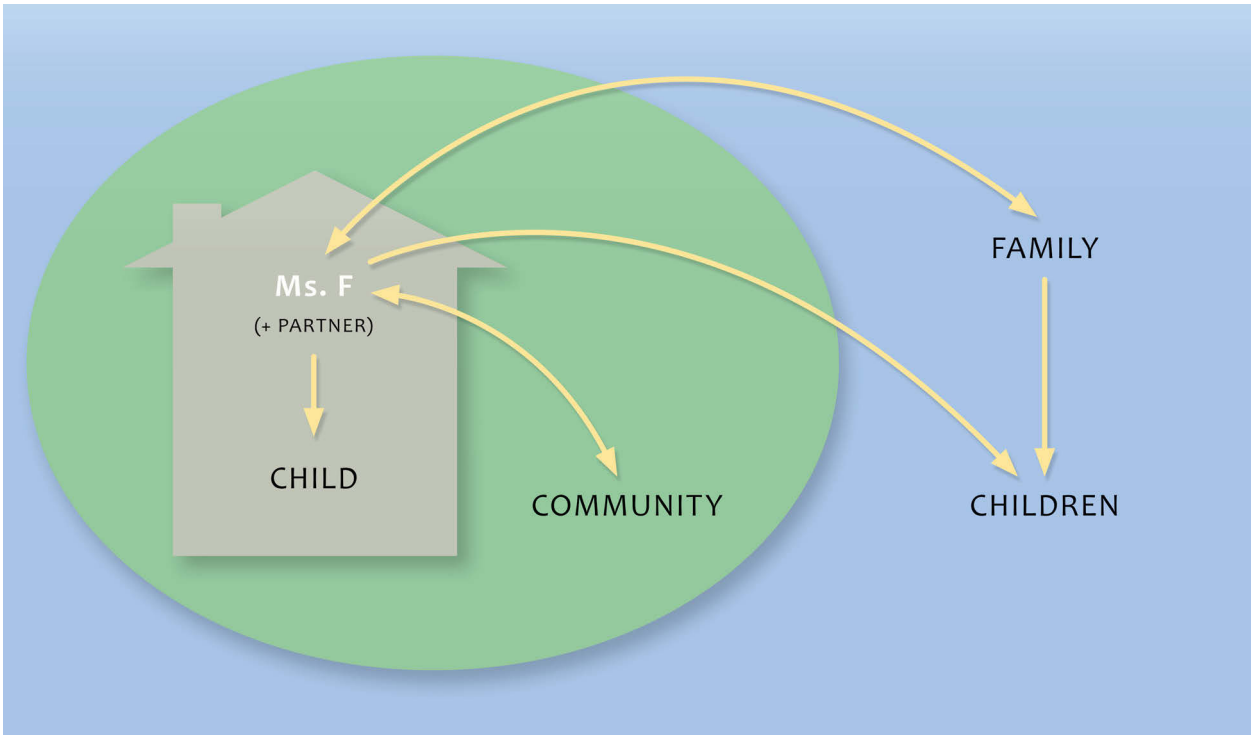
Figure 8.1 Ms. A's Care Relationships



8.2 Profile: Ms. F

Ms. F and her husband left their home country and claimed refugee status in Canada approximately five years ago. Their initial claim was rejected and they are currently in the process of appealing the decision. Meanwhile, her husband works and they have had a child. Their two other children remain in their home country living with family members, waiting for their parents to receive the legal status necessary to sponsor them. Ms. F and her husband send financial support overseas. Ms. F is an active volunteer in her community and place of worship, working with other newcomers, sometimes caring for their children while they attend appointments.

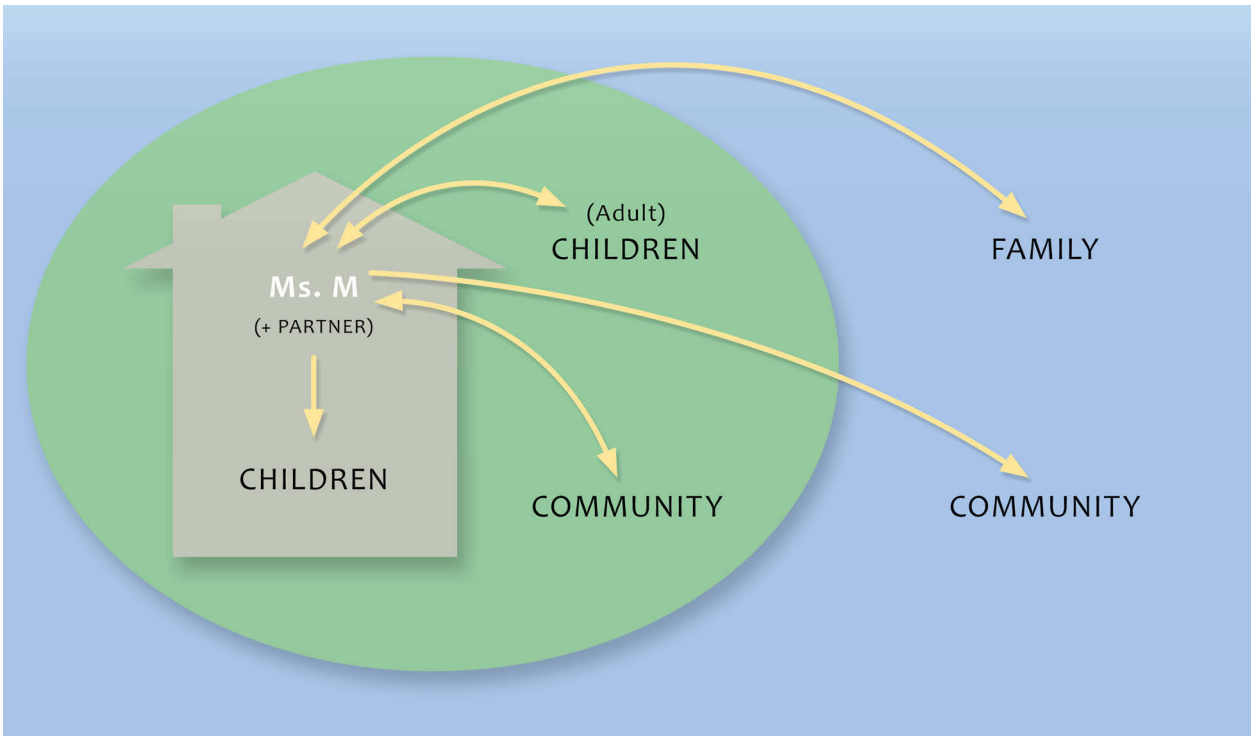
Figure 8.2 Ms. F's Care Relationships



8.3 Profile: Ms. M

Ms. M fled her home country to take refugee in a safe secondary country with her husband and children. While there, she formed an organization to help her refugee community advocate for status and find safe countries to settle in, despite this leadership role being unusual for a woman in her culture. Ms. M and her family were accepted to come to Canada as government-assisted refugees over 15 years ago and now have Canadian citizenship. Since in Canada, she has taken an active leadership role in her local community, bringing women of her cultural together and volunteering much of her time to create a grassroots women's organization; as well as, volunteering and organizing with women overseas still living in her home country. Her other family members live in various safe countries around the world and she keeps in frequent contact with them.

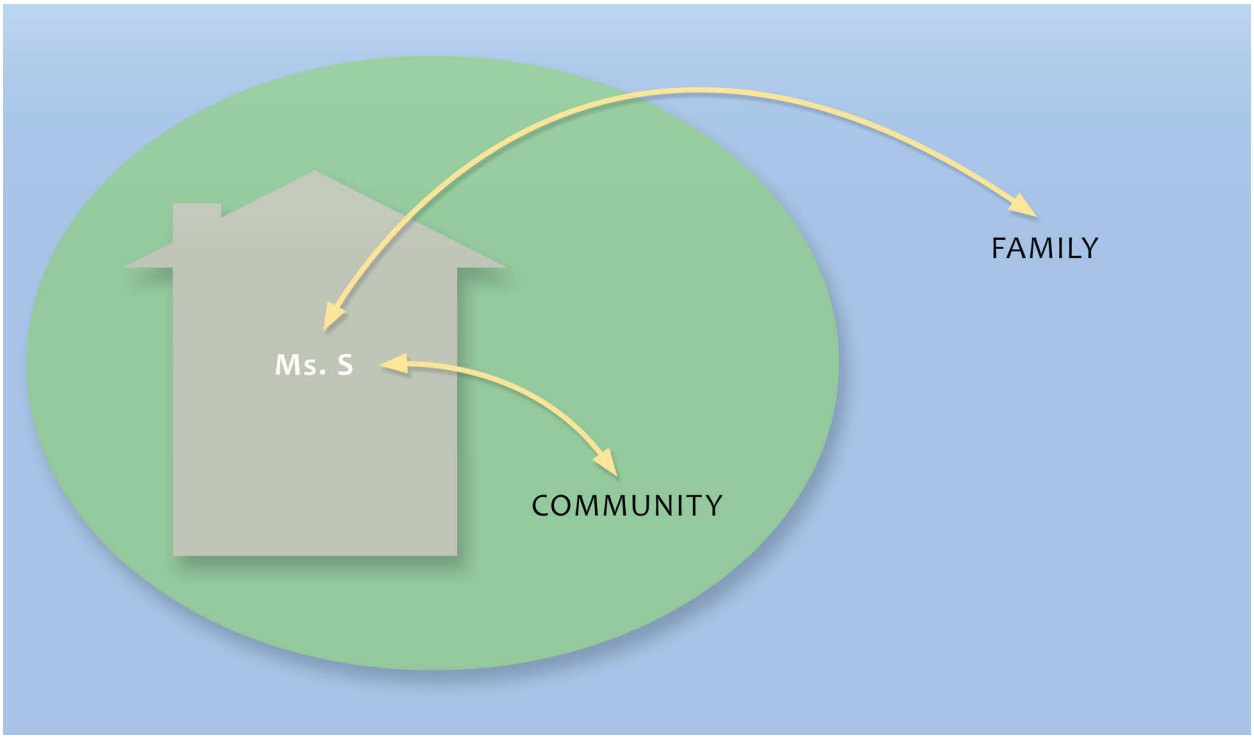
Figure 8.3 Ms. M's Care Relationships



8.4 Profile: Ms. S

After post-secondary studies abroad, Ms. S was not able to return to her home country but instead united with her family in a second safe country. While there, events unfolded regarding her future that led to conflict between her parents and extended family and put her in immediate danger. She escaped violent threats and became a government-assisted refugee in Canada. Now she has lived in Canada as a permanent resident for over a year and actively volunteers in a women's community organization and within her refugee community. She keeps in contact with her family overseas, whose applications to come to Canada were rejected.

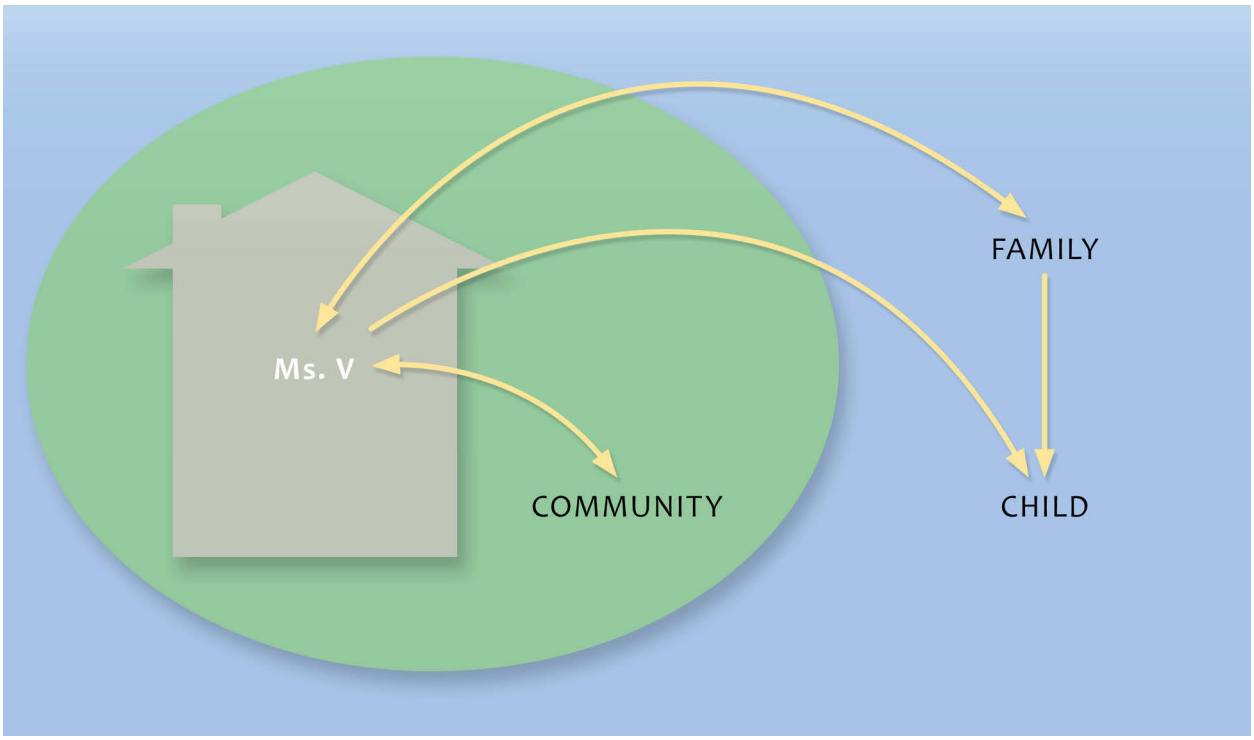
Figure 8.4 Ms. S's Care Relationships



8.5 Profile: Ms. V

After divorcing her husband, Ms. V and her child claimed refugee status in Canada over 10 years ago but were rejected and returned to their home country shortly after. She returned to Canada with temporary visitor status, while her child was cared for in her home country by grandparents. While living in Canada, she met her current husband, who later was able to sponsor her and her child. She has since been reunited with her child and sends financial support to her family in her home country. Throughout her time in Canada as a visitor and now permanent resident, Ms. V has been an active volunteer in her community and continues to volunteer in addition to her paid position in a community organization where she helps other women and newcomers. She and her now adult child continue to communicate with and send financial support to their family in their home country.

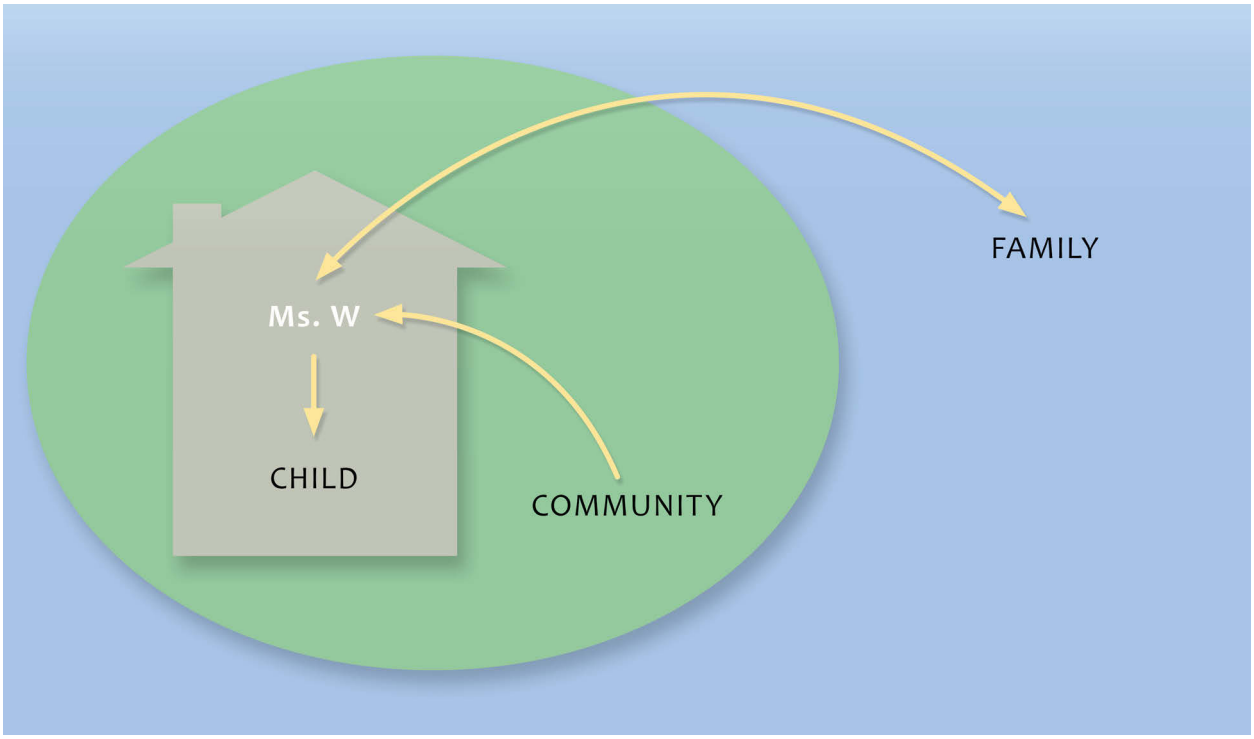
Figure 8.5 Ms. V's Care Relationships



8.6 Profile: Ms. W

After living with her husband's family in her home country, Ms. W, her husband, and child fled danger and claimed refugee status in Canada. She has been waiting over a year for a response to her claim, during which she had a second child born in Canada. Her husband has since decided not to continue with the process and has returned to their home country, effectively divorcing her. She spends her time caring for her children, engaging in the immigration process, managing her own health issues, and participating in community activities. She has some contact with her family in her home country, mostly relying on her mother for emotional support

Figure 8.6 Ms. W's Care Relationships



9 Caregiving Narratives from Refugee Women

The findings presented here come directly from the narratives of the women interviewed, focusing on the meaning they attribute to their own experiences of caregiving in order to gain a robust understanding of their lived experience of the phenomena of caregiving. This section has been divided into three major themes that focus on the setting of carework in order to highlight the different nuances, challenges, and benefits, of each care dynamic. The first section is on in-home caregiving and focuses almost primarily on mothers providing care for their children and partners in the home. The second section describes their experiences with transnational caregiving, including the experiences of caring for children, extended family, and community abroad. The final section discusses the carework the women do in their local communities through informal or official volunteerism and paid work. Each of these sections will discuss the instrumental and affective carework performed by these women, as well as accounts of being care recipients themselves. This breakdown will work to demonstrate the immense amount of effort, both physical and emotional, that go into carework and the dynamics involved in care relationships that can cause them to be the source of reciprocity, resilience, agency, and guilt. Ultimately, these findings will illustrate the value of caregiving and demonstrate these refugee women to be active participants and careworkers in many different care-settings, not simply passive care recipients as immigration policy and social perceptions often depicts them.

9.1 In-Home Caregiving

Five of the six women interviewed were mothers when they migrated; of them two women, Ms. V and Ms. W, experienced separation from their children during migration. While Ms. V has since been reunited, Ms. W cares for her youngest child at home while her two elder children remain abroad. Currently, Ms. W, Ms. F, and Ms. A are the only ones still caring for their children in their home. Ms. M's and Ms. V's children are now adults who live on their own or with their own families.

This section is divided into two major parts, focusing on instrumental labour and affective labour. Instrumental labour includes all of the caregiving tasks that require direct action. In the context of the home, these activities generally consist of, but are not limited to, the day-to-day activities of the household such as cooking and cleaning, as well as activities such as making appointments, tending to illness and general supervision. Affective labour in this context refers to the emotional care that takes place in

this context, including, but not limited to, emotional support, comfort and companionship. While these are two distinct sections, in carework, especially in the home, they tend to go hand-in-hand and the distinction between where instrumental care and affective care differentiate is not so clear-cut. For example, when a mother takes her child to the doctor it is an act of instrumental labour, but the words she speaks to that child to comfort and calm them is affective. These distinctions, however, are important because they help to illustrate the unique challenges and rewards of carework as well as the immense amount of effort, both physical and emotional, involved in carework. Notably, this in-home care is the only context where the women did not also talk about themselves as receiving care, confirming that within the domain of the household the women are almost entirely responsible for the care work and domestic duties. This may be because they are either the only adult within their household, or they come from a culture where husbands do not take an active role in this kind of labour.

9.1.1 Instrumental Care Labour in the Home

The women were asked to describe their typical day and many relayed descriptions of domestic duties or instrumental tasks of caregiving, such as cleaning their homes and cooking for their families, and other necessary caregiving activities, as taking up most of their time during the day. Ms. F and Ms. M described getting up extra early in the morning before everyone else to make fresh food for their husbands and children for the day. Ms. M also described getting up early to do domestic work in her home, so that while her children were at school and husband at work she could do her work in the community. These instrumental tasks allow the household and family to function. As Ms. F describes, “It is like a full time job” (translated).

All the women interviewed have noticed significant differences between caring for their families in Canada as compared to their home countries. For the most part the differences related to the support and pressures of extended their families, whom they were near to in their home countries—for example, family members living close by to help babysit their children, but also expecting to be part of the decision-making process regarding their children. They also spoke of differences in cultural expectations relating to the role of women in the family and society, primarily that their role as caregiver in the home would be their only priority.

The women interviewed each had different experiences caregiving in their home countries. Often extended family, including their parents and siblings, were very present in their nuclear families and, in some cases, acted as primary caregivers for their children. Ms. F explained that, for her, the biggest difference between caring for her children in her home country and caring for her child here is the feeling of support she had from her family in her home country. “You have lots of support,” she explains,

> If there is something that needs to be done on your own, you can leave your kids with extended family. You don't have that kind of feeling like, what should I do? Where should I leave them? But here, I am doing the same care but, for me, I cannot leave her alone, anywhere; there is nobody. So it means that even for a little thing, I have to go, I take her with me. There, it was not like this. (translated)

Not all of the women talked so affectionately about their families back home; rather, for some, leaving the pressure and judgment of their extended family was a relief. After marrying, Ms. W moved in with her husband's family, where she and her child eventually lived while her husband worked in another country. From that point on, her in-laws controlled most of the major decisions in her life. They forced her to leave her job as a teacher and controlled the way she raised her child. Ms. W described her in-laws indignation that she gave birth to a daughter and became very critical of her as a mother. Ms. W explains,

> When my daughter was born, they were not happy, but they wanted to control the way she should be raised. So during the whole day, she only was given to me when I was supposed to feed her. Otherwise, all the time she was with them and I could see that she was not properly raised. And she was learning things that, according to me, a child should not be learning. So there is a big difference, because there you cannot say, you cannot protest that I don't want this. You have to listen and obey whatever is told to you. Here it is different. (translated)

While she concedes that it has been very difficult to raise her children in a new country by herself, she adamantly believes that being free to make decisions for her family is worth all the difficulties. She states,

> With that pressure, continuous pressure, I was not in a position to take care of my kid properly. Here I have many difficulties, there are always difficulties, but that pressure is not there. So with less pressure of that kind, I am able to look after my kids better. I have faced many problems. My husband left me; I have to take care of everything, not only in the house, but outside the house, everything. But that mental pressure that I was going through is not there. I can look after my kids; I can enjoy them. (translated)

Ms. M talked about how common it is in her cultural community, both abroad and in Montreal, for husbands to make all the major decisions for the family, with wives having relatively little agency. Many women do not leave their homes, as their husbands do not approve. Ms. M described her marriage as traditional like this in many ways, but also comprised of mutual respect and admiration. Her husband supported her in her many activities outside the home, which was seen by some in their cultural

community as unusual. However, she jokes that he was her "biggest child" and acknowledges that "he asks for more service from me," as compared to contemporary Canadian marriages, because that is the way it is done in their culture. While asserting that it is important for couples to keep a sense of culture from their home countries, she also advises men and women from her cultural community to learn about Canadian culture and talk about respect and equality in their home lives.

Ms. S is the only woman interviewed who does not have children. She explained that does not want a traditional family as structured by her cultural norms, despite feeling extreme pressure from the extended family in her home country. She wants to study, to work and be free from the traditional roles women play in her home country. Even though she also experiences pressure from her cultural community in Montreal, she is able have more control over the kind of family and life she wants to have now.

9.1.2 Affective Care Labour in the Home

Caring goes beyond enacting certain instrumental tasks, but also includes emotional care. Ms. A describes her role as a mother as consisting of putting on a brave and happy face for her children, especially when they were young. Even though their life in Montreal was not easy and they had considerable concern for their family back in their home country, she wanted to protect her young children from these realities as they were growing up. When they first arrived in Canada and circumstances in her home with her husband were not going well, Ms. W took action for her own self-care and that of her child. She liked to spend time in the park with her child to take her out of that environment. She describes,

> So this way, our mind changed, attention was changed and we feel better, instead of sitting at home in the same environment. It was making me depressed and my daughter was having those same effects on her, which I felt was not good for her. So that's why we used to go out. I didn't know anybody, so it was a way of socializing too, where my daughter can play with others. It gave us relief from what we were going through. (translated)

Emotional care or affective labour for both Ms. A and Ms. W was a matter of protecting their young children from the difficulties that the family was going through.

Some women encountered unique childcare challenges, especially regarding healthcare provisions. Ms. F's child, who was born in Canada, lives with a difficult medical condition, for example. Ms. F described how difficult it was when they first realized her child was sick. She described feeling "sad, upset, depressed" (translated) because it felt like she had to take her child to the hospital every day. The problem persisted for three year and doctors had only recently found a treatment that seemed to help control her child's symptoms. Being unfamiliar with the Canadian healthcare system and language

added to her stress, as well as not having family or trusted friends close by to whom she could turn to for emotional support or help with her daughter. "I never used to leave her alone," explains Ms. F, "because I never have the satisfaction that she would be okay. Anytime anything can happen, so I used to be with her all the time, day and night" (translated). Since experiencing some success with the newest treatment in controlling her child's symptoms, Ms. F has been able to enroll in a French class and finally feels comfortable enough leaving her child with other childcare providers during that time.

Ms. W's child, who was also born in Canada, was born prematurely and also has been closely monitored by their doctor since birth. Ms. W herself lives with a medical condition that was intensified by trauma she experienced before and during migration and the subsequent stress of her husband leaving their family. Managing her own health and the health of her youngest child are among her greatest priorities right now. Ms. W has had a very positive relationship with her doctor from the beginning, and sees her doctor as a trusted person in her life who provides her with both medical and emotional support. Prior to finding her doctor, Ms. W was taking medication for her health condition that was prescribed to her in her home country but she had not been warned of the effects it could have on her pregnancy. She expresses great appreciation for her doctor and the health system in Canada for having taken the time to do the right tests and explain things to her, saying this was a big difference from her home country that had a significant impact on her life and that of her child. Ms. W talks very fondly of both her children and appears especially proud of her eldest whose personality she has seen blossom since she has started school, describing her proudly as assertive, intelligent and social.

9.2 Transnational Care

All of the women who were interviewed participate in transnational caring relationships with family members and communities overseas, including their parents, siblings and other extended family. Often the women, sometimes together with their spouses, act as transnational caregivers. For some of the women interviewed, family separation has included separation from their children. Both Ms. F and Ms. V experienced separation from their children during the migration process and initial settlement stages in Montreal. Ms. V was eventually reunited with her child, who was sponsored to come to Canada by her husband. Two of Ms. F's children still live in her home country with her family. Additionally, care for aging parents overseas, as cited by Ms. A, Ms. V, and Ms. W, and worries for the safety and economic situations of extended family and community overseas were common features of transnational caregiving that were discussed. Some women also spoke of the reciprocity of their transnationally caring relationships, as sometimes they are also transnational care recipients as well.

These relationships are characterized by both instrumental care labour and affective care labour. These activities take on different forms in the transnational care context as compared in to when carried out directly, in the home. The first section discusses transnational instrumental care labour,

which primarily includes arranging for alternate caregivers, sending financial support and attempts at sponsorship to immigrate to Canada. The second section describes transnational affective care labour, which includes various forms of communication, emotional support and comfort. The final sections discusses the interview participants' experiences as transnational care recipients—for example, when they receive emotional support during their migration and settlement and the support they feel when family members overseas take on additional care responsibilities, such as caring for their children or aging parents. The common insight regarding transnational care, both instrumental and affective, is that it is incredibly difficult and the challenges it presents, both practically and emotionally, overshadow any positive feelings, which were very present when they discussed direct caregiving in their home.

9.2.1 Instrumental Care Labour Provided Transnationally

Instrumental care labour done transnationally consists of a different set of activities than instrumental care done directly. For example, when done directly, instrumental care may require preparing a meal; when done transnationally, instrumental care requires arranging for a substitute caregiver to attend to this task and sending that substitute caregiver money to purchase the food, necessary supplies and compensate them for their time. In the context of the family, transnational care is viewed as a last resort for the women interviewed. In nearly every case, especially when family members were viewed to be in danger or had special care needs, the women would have preferred to be able to provide care directly.

Attempts at family reunification through sponsorship or other immigration support are another form of instrumental care. Only one participant, Ms. V, has been successful in family reunification. At least three others, Ms. A, Ms. F, and Ms. W expressed desires for family reunification and have either attempted to sponsor family members already or have plans to. Ms. M, whose family members are in a comparatively more stable environment compared to the other interviewees, directed her transnational caregiving to the community she left behind in her home country. Instrumental care labour in this instance took the form of financing and organization community projects transnationally. Transnational instrumental care labour will be discussed first as it was experienced in the context of the family and secondly as directed towards communities.

9.2.1.1 Instrumental Caring for Family Transnationally

Offering financial support to family members in their home countries or elsewhere overseas is one way members of transnational families are able to care for one another; however, due to other factors and obligations this is not always feasible for every family. Ms. A describes how her parents' health has become a major concern for her as they age. Where they are living they do not have access to public health infrastructure, so it falls solely to families to care for their elder family members. She would

like to be able to care for her parents in Canada, and she and her husband have tried to sponsor them. After doing the work of filling out and filing the appropriate forms and paying necessary fees, their application was rejected and she is unsure of the reason. Presently her family income is not enough to be able to send financial support to them while also providing for her children here. While she would like to care for them, and sees it as part of her duty as a daughter to do so, she feels helpless, as she has been blocked from providing her time and unable to contribute through financial resources.

Ms. S too would like to be able to contribute financially to the well-being of her family overseas and eventually sponsor them to live with her here. Her parents and siblings also applied to be government-assisted refugees in Canada, but were denied for reasons she was not certain of. Currently her income is only enough to cover her most basic needs, but she feels hopeful that she will be able to contribute to her family's well-being in some way in the future, either through sponsorship or remittances.

Ms. F and her husband send money to help support their children overseas who are living with other family members, in addition to providing for their child who lives with them in Canada. Ms. F describes how many of her children's basic needs are covered by the family members they live with, but she and her husband cover all the costs of their education. Because of the inadequacies of the public school system where her children are living, they must cover the full cost in the private system, including books, supplies and uniforms. She describes this cost as one of their "biggest expenditures" (translated). During the first few years in Canada, it was really difficult for them to be able to send this financial support due to their household income; however, eventually her husband was able to find a higher-paying job and the costs became more manageable. She explains, "He is making somewhat enough money that we are able to manage and we can send. It is not much, but at least we are able to send proper support back home for the children" (translated). As their refugee claim in Canada is still pending (after being initially rejected, they are in the process of undergoing an appeal), they do not have the legal means to sponsor their children to live with them in Canada currently. If the appeal goes in their favour and their claim for refugee status is approved, they will be given status as permanent residents and may include their children living abroad as dependents on their application.

Ms. V also sent money to her child and parents during their separation, and continues to send financial support to her parents. She was able to reunify with him when her husband, her child's step-father, successfully sponsored them both as dependents. Now that her child is an adult and is also working, they are able to share more the responsibility of sending financial support to their family in their home country. Her parents are not covered by public health insurance in their home country, so when they become sick it can be quite expensive for the family. She shares caregiving responsibilities for her parents with her sister who still lives in her home country, explaining, "Physically she is there, but economically it is me." Ms. V describes how in the beginning this arrangement was sometimes difficult for her to manage, but it is getting better now that she has consistent paid work and her child, who is now grown, is also able to contribute small amounts. "Always it is difficult because the money is not

enough," she explains, "Always the situation in our country is not easy… We try to send money every month… We take care of them." While she is happy that she is in a place in her life where she can take care of her family and send financial resources, sometimes she finds these responsibilities frustrating, as it often means making sacrifices in her own life.

Although Ms. V says it is getting more manageable now, when she first started sending financial support transnationally to her child, it was incredibly difficult—not only because of financial strain but also due to guilt associated with the separation. This is a common struggle for many migrant women she knows and works with, not only herself. "You have to decide if you eat or if your [child] or family eats in [your home country]," she explains. Although she also knows many men who work and send financial resources to their families abroad, in her experience mothers feel much more pressure to send money to compensate for not being present to care for their children or are more driven by emotions of guilt rather than a practical assessment of their own immediate needs. These conditions can be enflamed when that mother is also living with precarious immigration status and precarious work, and families living far away do not always understand the severity of the situation. Speaking of her own situation and those of many women she has come to know, Ms. V explains,

> You are very vulnerable and really we are ready to do anything, because the responsibility doesn't end. We have to send the money every week… You work hard, you send money, but it's always never enough, because they tell you sometimes, 'Why are you not here? Your [child] is here. They need you…' Our feelings, our guilty feelings, they push us to do things wrong sometimes… We have to learn how to manage our feelings, because if not, our feelings are acting against us sometimes… How can we survive hard conditions when we don't take care of ourselves?

These narratives illustrate the difficulties of transnational instrumental care labour. Families engaged in numerous strategies to provide instrumental care for their family members overseas. These strategies include attempts at family reunification (for example, Ms. A and her husband tried to sponsor her parents), sending financial support overseas (for example, Ms. V and her son send money to support her parents) and arranging for alternative caregivers (for example, Ms. F arranged for her sibling to care for her children overseas).

9.2.1.2 Instrumental Caring for Communities Transnationally

Although she is now far away, Ms. M still has a caring heart for the people of her country, particularly women living in poverty affected by the on-going war. "There are no problems with my family. My stress is we are thinking about the poor people in our country," Ms. M explains. She has sought out different aid organizations and wants to devote more time to this cause. In the past she fundraised individually to

go back to her home country and set up a community economic development project catered to the needs and abilities of women living in poverty in her home country, providing them with the skills and equipment to start their own small businesses and support their families. She laments, "After one year, the project no longer exists, but I did this job for these 20 women." Although her family and local community work occupy much of her time, she continues to look for other opportunities to contribute to communities in her home country.

9.2.2 Affective Care Labour Provided Transnationally

Apart from sending financial support and other instrumental care activities, maintaining regular communication and providing emotional support through communication are the primary care activities common to all the women interviewees. This section discusses how these women use communication, primarily regular phone calls, to maintain familial connection and emotional support transnationally, and the particular challenges they experience in caring for their children and their extended families transnationally. These phone calls and other communication are an affective care activity because of how the contribute to the mental health and emotional well-being of the family by allowing a continuity of relationships despite distance and a means of emotional support and sharing.

9.2.2.1 Affective Caring for Children Transnationally

Ms. F has two children in her home country who are cared for by one of her siblings, as well as her youngest child who lives with her and her husband in Montreal. She keeps in frequent contact with her children through telephone calls every day or every other day, saying if she does not call they become very upset. Even though her children have a good relationship with the family members they are staying with and Ms. F feels confident they are loved and well-cared for, her children tell her they are not happy and they want to be with their parents. Thus far, it has been five years since they lived together as a family. She is hopeful that one day they can be reunited, but feels very uncertain about her family's future in Canada, as her and her husband are in the process of appealing their rejected refugee claimant status. Caring transnationally has been a difficult burden for Ms. F and her family, and her sadness is evident when she speaks of her situation. She explains,

> I feel that the time when I am not there, when they are, they need my love, my care. I am not able to give it to them. I am away from them. So they are growing now. I feel like they are missing that and I am also missing that. (translated)

Ms. V has also experienced separation from her child during their migration and settlement in Canada. Although they initially migrated together, circumstances surfaced, relating to her child's integration and mental health, such that it was best for her child to return to her home country to live with her parents temporarily. She also describes this as a difficult time for her family, and as a mother, "always feeling guilty." She described her son as feeling very emotional and angry:

> A lot of times, I just wanted to go to the airport and get a flight [to be with him]. But always I think that, what can I do there? I do not have a job. How can I live? How can I help?

Ms. V decided to talk to a therapist in order to manage her feelings of guilt and helplessness concerning her separation from her child and says without this help she probably would not have been able to deal with those circumstances. Even now that her and her child, now an adult, have been reunited and they are both settled in Montreal, she feels guilt about the past. She explains that the reunification was not an easy process; there was tension in their relationship due to the separation. Her child has also spoken with a therapist, who has eased the tension and she now describes their relationship as positive and generally mutually supportive. She acknowledges that her child "sacrificed" her presence, but they now have to work together to move forward. When her and her child reflect on their life now, she tells her child, "We made it together… And this is what we always wanted. I have a job now. You are here. You are building your dreams. You are building your life now."

9.2.2.2 Affective Caring for Extended Families Transnationally

Ms. A, Ms. M, Ms. S and Ms. W all use routine phone calls to communicate with their parents and siblings in their home countries or other countries abroad. Ms. A and Ms. S say they limit their telephone calls to once a month due to the cost. Because of the cost of long-distance telephone calls, Ms. S describes how she mostly relies on internet-based communication, such as Skype and Facebook. Communication difficulties with her family are exacerbated because they do not have consistent access to electricity where they live, restricted to only two hours in the evening.

Ms. A and Ms. S describe how these telephone calls can be emotional. They receive updates regarding their families and the insecure situations in their home countries. For those whose extended families are still in danger, they are constantly concerned for their well-being. Ms. A is often sad after these telephone calls, but explains that because she is a mother, she must be brave and strong for her family. She does not want her children to be sad or sense that there is any trouble. Ms. S also describes putting on a brave face for her family overseas. Ms. S has faced her own difficulties here during her settlement, but says she does not want her family to know that she is sad and worry for her. Instead she tells them about how she goes to the park and is learning French and tries to keep their conversation happy and

hopeful. Both Ms. A and Ms. S adopt a protective role toward those they care about, often with their own true feelings or self-care as a secondary concern.

9.2.3 Care Received Transnationally

Not only are the women interviewed caregivers to family members abroad, but many are also care recipients who experience family members caring for them transnationally, as well. Similarly, they have benefited from consistent communication with family members in their home countries, which allowed them to feel familial connection and emotional support. Additionally, the women are also recipients of care when family members agree to fill care deficits they leave behind when they migrate—for example, when Ms. V's parents took on the responsibility of caring for her child. In this case, the substitute caregiver also provides a kind of affective care for the person who migrated by providing necessary care for their children or elder parents.

Ms. W is alone in Canada taking care of her children, and is only in regular contact with her mother in her home country. The conditions of her migration and the break-up of her marriage have made it difficult to connect to other members of her family or her cultural community. Her mother, however, she describes as a source of "emotional support" (translated). She explains,

> Because my mother knows everything about what I have been through in [my home country]. So keeping that in mind, she always tells me at least in this society it is different. You don't have to face any other negative things from the society. (translated)

Her mother also gives her practical advice regarding her children, their health and her own health—for example, quick, easy recipes to make for her children for when she is not feeling well. Through these telephone calls, Ms. W and her mother have found a way to support and care for each other and the children transnationally.

When other family members abroad agree to care for children or elderly parents whose primary caregivers have had to migrate, it is also a form of affective care for those migrating. Knowing that their children's direct care needs will be met by someone they trust helps to ease the worry of the caregiver while they are separated from those they would usually care for. In this way Ms. A's sisters provide her with affective care, while they directly care for her aging parents—a task Ms. A would be very involved in if she were not separated from them. Similarly, while Ms. F and her husband send money to help support their children in their home country, Ms. F's sibling has agreed to provide the day-to-day care for them while separated from their parents. Although the separation is very difficult, Ms. F knows that her children are being well-treated even if she cannot be there caring for them. Ms. V was also the recipient of care when her parents agreed to care for her son during their separation. She also currently

receives care from her sister, who provides the direct care for her aging parents in her home country. Ms. V contributes financially to the care of her parents transnationally, while her sister handles their direct care. These relationships and care networks allow care needs to be met in despite migration and changing family structures. Primary caregivers who migrate can therefore also be care recipients when alternate caregivers help fill care needs.

9.3 Caring in Communities

All of the women interviewed have supportive connections and relationships in their communities in Montreal. Many of them speak about how they have been both care recipients, receiving support from various community organizations, and volunteers themselves, providing care and assistance to those in need of it, often through the same organizations. Because none of the women interviewed have extended family with them in Montreal, community connections and relationships are important part of their lives as sources of support and information.

Ms. F, Ms. S, Ms. V, and Ms. M have all done extensive volunteer, and sometimes paid, carework helping refugee women and others through different organizations or more informal agreements. Instrumental care labour in the community may consist of facilitating various classes and community services, accompaniment to appointments, imparting information and informal childcare, among other things. While discussing care labour in the community, the women interviewed also elaborated on their personal relationships and connections to certain communities and the emotional or affective labour that forms part of these interactions. Although here community carework has been divided into distinct instrumental and affective care labour sections, they are often practiced together.

Additionally, Ms. F, Ms. V, Ms. W, and Ms. A speak about the positive support they have received from community members and organizations. They discuss the relationships and friendships they have built through communities organizations, their children's activities and their religious places of worship, which have provided them with emotional and crisis support, information and social opportunities. Other figures, such as Ms. W's doctor, also have been valuable sources of care in the community. These positive experiences as care recipients in the community have been the inspiration for many of the women to do their own volunteer carework.

9.3.1 Instrumental Care Labour in Communities

Many of the women interviewed are not only members of community organizations, but active volunteers and leaders. Ms. M's story demonstrates a commitment to community carework, primarily in her commitment to the instrumental care labour of organizing a community space, where tasks included immigration help, information sessions and classes on various topics and small-scale community eco-

nomic development projects. Ms. V, Ms. F, and Ms. S also engage in community work with a strong instrumental care component.

Since Ms. M first began her migration journey, she has taken an active role in organizing and caring for those in her community. When her home country became too dangerous, her family, along with many other refugees like them, settled temporarily in a neighbouring safe country. She worked hard to open an office there to aid refugee men and women from her country. She speaks of having over 200 women members and international financial and political support, which enabled them to provide information sessions, language classes, community economic development projects and well as memorial events and cultural celebrations. Given the culture of her home country and the country they were in, it was very unusual to have a woman leading such an important and influential organization. Ms. M laughs as she remembers the opposition and reluctant acceptance of her position by the wider community: "That organization provides help for refugees, very new. That is interesting—a woman on the top!" This organization eventually took on a more central role in the immigration and re-settlement process for refugees from her home country. Through this process, Ms. M and her family were also encouraged to apply for refugee status and were accepted to come to Canada. While she was thrilled that her family could live somewhere safe, she also felt pain at having to leave behind the organization she had built and the people they were helping. "How is it possible to leave everything and got to Canada?" she recalled thinking to herself, "But Canada is my dream! What can I do? Believe me, many nights I did not sleep well." She was able to negotiate with the Canadian Embassy where she was living, and they agreed to give her six months to make arrangements for the transfer of her organization to new management. On the last possible day, she arrived in Montreal.

After settling in Montreal, she identified the need for a similar centre catered to the needs of immigrant women, particularly from her cultural community. By networking with numerous community organizations around Montreal she has been able to develop a centre catered to meeting these needs. Consistent funding for the centre has been her biggest challenge, which has at time restricted programming and access to space. Even when this meant having to hold meetings in metro stations, Ms. M stayed committed to community and the idea that women from her community needed a safe space to socialize and learn together. "I wish for women to be educated," Ms. M explains,

> They need to learn. They need to learn for new society, new up-and-coming life. You have to learn for new community, new society, new system. You have to learn to adopt them to continue… You should not forget the culture—keep the culture, but also the new. I want to give opportunities for women to learn the new system, gain new knowledge.

In her efforts to do this work, she has helped arrange language and computer classes, workshops on different health topics and family violence and small economic development opportunities, as well as created a space for women to gather together and share. According to their culture, it is deemed most appropriate

for women to stay in the home and many husbands Ms. M talks to prefer it this way. She goes to great efforts convincing them that allowing their wives to participate in these activities will be beneficial for their whole families.

Ms. F, for example, volunteers at her religious centre, as well as two other community organizations. Most often this work entails working with newcomer women or young people, accompanying them to appointments with lawyers or immigration, helping them access health services or teaching newcomers how to use public transit. Ms. F explains,

> Because I understand their situation—you are helpless, you don't know and you need somebody to give you support. These things I have experienced, so I like giving that back to other people… Like people helped us when I was in that situation, so when it came to the point where I thought I could also do the same kind of service, they benefit like I benefited. I like doing it. (translated)

This kind of accompaniment volunteerism was sometimes difficult because Ms. F has to bring her child with her, which could be often times challenging and could make appointments more stressful. In other cases, Ms. F volunteers to take care of other people's children so they can attend the appointments they need to without having that worry.

Ms. S and Ms. V both have this same perspective on the volunteer work they do—they both know how lonely and how difficult it can be when newcomers first arrive and want to help others who might be going through the same thing. Ms. S meets newcomers through her language classes and other newcomer programs and makes an effort to be social and provide them with information. Ms. V described how doing community work is not only beneficial for care recipients, but gives a sense of purpose and empowerment to those volunteering.

9.3.2 Affective Care Labour in Communities

In many cases, the community instrumental carework is closely connective to the affective care the women show for their communities. Their stories highlight the importance of relationship-building, emotional support and opportunities to come together and share. Although Ms. V engages in many instrumental care tasks in her community, her story highlights most clearly the impact of affective care labour. The focus of her work comes from the strong connection she has with migrant women and their struggles; a genuine 'caring about'. She describes the importance of women being able to come together and share and has made this the starting point of a lot of her work. This kind of affective labour can also be seen in the work of Ms. F, Ms. M, and Ms. S.

Ms. V in her community work has also spent much of her time working with women and believes it is important to understand the unique situations women are dealing with in migration. In the orga-

nization she work with, she finds it is more difficult to get women involved. They are too tired after working, they have other responsibilities at home like childcare and cooking or they have partners who are discouraging them from becoming involved. Communicating with women who may benefit from the organization and trying to initiate those relationships is the most difficult part of her work, according to Ms. V, saying it is difficult to persuade them that "things can change if you come together." She has introduced various strategies to encourage women to become involved with the organization—from providing childcare and developing social activities that are fun but also inspire them. The rewards of coming together are beneficial for many women in need, but also for Ms. V. She explains,

> I am really thankful that I can know them closely, more friendly. And I have this opportunity to be close, to be part of their lives and they are part of my life also. It is very enriching in my life. They give me a lot of things to learn and to share. I love my job. And I am so happy… Because our background is different, but at the same time, it's the same. We have a lot in common. It's incredible how powerful we are when we come together. It's incredible!

Ms. M also comments on the emotional support women in her community get when someone does the work to bring them all together. This, she notes, was especially important for women, especially those otherwise isolated due to culture, language or mobility, who may have few opportunities to socialize and share with others. Ms. S discusses feeling alone and isolated upon first arriving in Canada and how that experience has prompted her to reach out to other newcomers.

9.3.3 Care Received in Communities

Many of the women interviewed referred to specific community organizations where they received information and support, as well as social opportunities that allowed them to develop social networks and friendships. Through these relationships, they benefit from both instrumental and affective care labour from their communities. Ms. A, Ms. F, Ms. S, and Ms. W each continue to maintain their connections and participate in community organizations, while Ms. M and Ms. V have, in addition, taken on leadership and caring roles within their organizations. The women have relied on organizational staff and the social network that they developed for advice and information on employment problems, health access and immigration, as well as information and emotional support regarding intimate relationships. Ms. M emphasized the importance of programs in community organizations that bring women together, explaining that, "They are very close friendships—'I know you after I came to the centre.' The centre gave them the opportunity. Otherwise they cannot go anywhere but home. There are no relatives, just their friends."

The women also spoke of developing friendships and caring relationships with people they have met through their language classes, religious centres, their children's schools and other programming

and just in their neighbourhoods. Ms. F has been able to develop strong connections with women from the religious centre she attends regularly. They help each other out by watching each other's children sometimes, although due to her child's illness Ms. F still feels hesitant about leaving her with someone else for too long. Ms. W has been able to develop friendships with parents she has met at her child's school and other programming she attends with her children. Caring for her children has thus also allowed her to develop her own caring network of supportive relationships.

10 Discussion

This section provides an analysis of the findings using the ethics of care conceptual framework and literature provided in the previous sections. This analysis will focus on understanding the challenges of doing carework in home, in local communities, and transnationally, as well as how to attribute value to these activities. Additionally, the analysis will include an exploration and critique of the ways in which the care and immigration policy intersect.

10.1 Understanding Challenges and Finding Value

These six narratives demonstrate some of the difficulties involved in caregiving and carework at home, transnationally, and in communities. These challenges include finding strategic ways to accomplish the physical tasks involved in providing care while facing significant barriers, such as low income, little family support, or significant geographical separations. For the women interviewed, these tasks also had to be managed while learning how to live in a new and unfamiliar society, to make use of appropriate services to ensure the family's needs are met—for example, Ms. W asking other women she met in the park the best way to find a doctor. Additionally, Ms. A, Ms. F, and Ms. V all discussed managing their caring relationships, specifically making decisions that sometimes meant balancing resources between their families in Canada, their own self-care, and their responsibilities to their family abroad. In a different context, Ms. M had to make a choice about the care needs of her community in her temporary country of refuge and the benefits to her family if they permanently immigrated to Canada.

Care is emotionally challenging. As discussed in the literature, care is not only comprised of instrumental tasks or *caring for*, but also affective labour or *caring about* (Gutierrez-Rodriguez, 2014). The emotional components of carework, whether paid or unpaid, combined with the social pressures to meet the expectation of being a *good mother* create an enormous amount of guilt in caregivers when care expectations cannot be met in the way in which caregivers hope or deem to be ideal. As the literature discusses, it is easy for caregivers to become *prisoners of love*—for example, hired childcare providers are more likely to accept poorer working conditions because they *care about* the children they are *caring for* (Folbre, 2001; Folbre, 2012; England, 2005). Similarly, as Ms. V describes, based on her personal experience and those of the women from the community she works with, any caregiver desperate to provide care to those they care about will be more tolerant of poorer working conditions and prone to

self-sacrifice in order to have the necessary income. This likelihood may be heightened, according to Ms. V, when these caregivers are mothers caring for children transnationally who feel especially pressured to make up for their absence in their children's lives and fulfill the role of a good mother. Ms. V provides accounts of mothers feeling like they have to choose whether they themselves eat or to send money to their families or children abroad. Ms. A and Ms. S give accounts from their own lives of choosing to mask their own feelings and mental struggles so those who need them will see them as pillars of strength and success in their families. While there may be a tendency to characterize this guilt as a *mother's feeling*, the literature indicates that it is a product of carework itself. For instance, Ms. M also felt an element of this guilt when she chose to leave behind the community she was caring for in her country of refuge to migrate to Canada.

As the global care chain framework outlines, when a caregiver leaves a community, it creates a care deficit that must be filled by someone else (Hochschild, 2000; Yeates, 2004). Most often this requires a familial adjustment—for example when one of Ms. F's siblings became the primary caregiver for her children who had to stay in their home country. It could also mean a vacancy in the community—for example, Ms. M was a clear community leader in her country of refuge and struggled to find someone who would be able to fill that role upon her migration. As was demonstrated in the discussion regarding the economic-driven careworker migration in the global care chain framework, being cared for by a family member or preferred caregiver is an economic privilege. Those with less economic privilege are more likely to experience separation from their family, and therefore their primary caregiver, than those with more resources. This was demonstrated in relation to labour migration using the global care chain framework, and it is also evident within the Canadian refugee and family reunification processes, in general. If a family meets the economic criteria and can afford the necessary fees, they have more opportunities to migrate together as a family and reunify with extended family, as compared to those with less economic privilege.

The majority of the participants indicated that they felt the effects of their limited economic resources and the choices made during their migration, especially regarding separation from their families, on a daily basis. In many cases, the choice to separate from certain family members has taken a toll on the whole family. As many mothers who migrated separately from their children, whether for economic reasons or seeking refuge, explained, they experience an enormous amount of guilt and feelings of inadequacy regarding the normative duties of motherhood (Salazar Parrenas, 2001; Bernhard et al., 2005). Refugee mothers interviewed for Bernhard et al.'s study (2005) emphasized that family separation was not a desirable migration strategy, but was only done out of desperation and at huge social and emotional cost for the whole family. The refugee women who participated in this study, especially those who have experienced separation from their children, like Ms. V and Ms. F, echo these statements.

What the narratives provided by these women show is that while doing carework can be empowering and meaningful, doing it transnationally is incredibly taxing and sometimes disempowering. Generally, however, when the women interviewed discussed their different caregiving roles it was evident that these

relationships brought a sense of meaningfulness and gave them pride, and both allowed them to foster their own strength and resilience, and extend their own sense of agency. The obvious beneficiaries of caregiving are the care recipients, but in many ways carework is valuable for caregivers, as well. While commonly, carework and care responsibilities are framed in the literature and general public discourse as burdens for caregivers (for example, to gaining employment), the perspectives that the women interviewed provide indicated that there are also many positive gains that make their carework extremely valuable to them on a personal level.

One example of the positive value of carework on a caregiver is Ms. W's story—freely engaging in caregiving tasks for her children provided her with a sense of agency she was not able to exercise in her home country. Prior to her migration, Ms. W was not in position to make many decisions regarding her life or the care of her children. Since moving to Montreal, she has encountered many additional challenges. As she explains,

> Migration is not an easy thing. You have to leave so many things behind. One part of you is still there, but you have to look forward. In the beginning when I came, we didn't even have anything to sleep on. So I would think, 'This is bad. At least I had a bed there.' But then I started thinking, 'I had a comfortable bed, but my life was not comfortable there.' Here I don't have anything, but at least I don't have to face the things I was facing there.

Ms. W has become the sole decision-maker in her family, and the primary way this new agency has become realized in her life is through the choices she makes in providing care to her children.

The women who provide care in their communities also experienced a new sense of agency. Upon arriving in Montreal, many had felt relatively powerless or overwhelmed by their new situations; however, with time they engaged in and learned from their community and began to feel more at home in their new city. Being in a position where they now have knowledge about their community, their city and the immigration process has now made many of them resources in their communities, as they volunteer to help others going through similar situations. In this way, their carework in the community allows them to enact their agency and affirm their resilience.

All of the women interviewed who have children echoed similar sentiments regarding resilience—that through their care of their families, they were able to find strength to make it through the difficulties of migration. For example, Ms. A, Ms. F, Ms. M, and Ms. V all explained how hope for their children's futures was a contributing factor influencing the migration of the family. Ms. A, Ms. F, and Ms. V, who now have adult children, clearly feel pride in their children's accomplishments, including post-secondary education and career paths.

The literature on care overwhelmingly discusses care as a burden upon women—care responsibilities as barriers to employment and education, for example, or as a feature of their labour that ties them to

poor working conditions, as in the case of the *prisoner of love*—but little is said about the value of doing carework in the lives of the people who do it. To fully understand care, it is important to understand the challenges as well as the meaningfulness and positivity it brings to the lives of caregivers. By only focusing on care as a burden, care as constructed as a barrier to be overcome, which contributes to its devaluation. For the women in this study, while care responsibilities may have prevented them from obtaining employment or kept them in jobs with poor working conditions, it also built up their sense of agency and resiliency, and allowed them to frame the difficulties they experiences throughout their migration and settlement in a meaningful way.

10.2 Care and Immigration Policy

The literature presented has demonstrated that Canadian immigration policy favours approaches and programs that prioritize economic benefits for Canada over humanitarian or family reunification concerns. Although immigration policy continues to provide opportunities for humanitarian or refugee migration and family reunification, ultimately the trajectory of this policy development reveals an effort to restrict this kind of migration, or at least condition eligibility on economic criteria—for example, by increasing the required income for sponsors to be eligible to sponsor family members. Conversely, more and more programs have been developed or expanded that allow for immigrant workers to come to Canada—ranging from highly-skilled professionals to those migrating on a temporary basis to fill a variety of lower-sector jobs.

This economic focus in policy-making is consistent with neo-liberal political ideologies, which have had an increasing influence on Canadian policy-making. This ideological position emphasizes the values of personal autonomy, individualism, and free markets, which Tronto (1993), in her argument for the role of care in the political realm, contrasts with the ethic of care, which values care as a central component of society, acknowledging interdependence between people and the fundamental need for care by all people at some point in their lives. Under neo-liberalism, the autonomous individual is lauded as the ideal citizen, whereas care receivers are constructed as needy and dependent, with no political voice (Tronto, 1993). Tronto (1993) suggests that care can and should be used as a "tool for critical political analysis" (p. 172) that requires the examination of the interconnectedness of policy realms and the consequences of capitalist development.

Due to the circumstances of their migration, refugees are often in need of more comprehensive services upon initial settlement—including, but not limited to, physical and mental health services, transitional housing, language classes, and employment integration support. Conversely, economic immigrants may not have as many of these needs, as part of their criteria for acceptance to Canada may have included knowledge of one of the official languages and employment prospects. Therefore, in contrast to economic immigrants, those immigrating with refugee status are more likely to perceived

as primarily or only care receivers. This image is re-enforced by the relatively low employment rates of refugee women, as compared to refugee men and other women (CRIAW, 2015; Statistics Canada, 2010). Refugee women, in particular, have been constructed through Canadian immigration policies as non-contributors to society, relying on extensive government services.

What the stories of these six refugee women illustrate is that while many of these women may struggle to contribute directly to the Canadian economy, they contribute extensively through their care—in their homes and communities in Canada, and for their families and communities abroad. These stories demonstrate the value of care. Through care, these six women demonstrate that they have skills and they engage in meaningful activities that contribute positively to the lives of those around them. Furthermore, through these actions they demonstrate their own resiliency and agency. Canadian policies do not adequately recognize the value of care activities, and therefore their contributions go unrecognized and undervalued.

11 Conclusions and Implications

This project has provided a glimpse into the lives of refugee women in Montreal, in particular how their various caregiving roles are impacted by the circumstances of their migration. This project represents an effort to try to understand the breadth and complexity of these roles amidst a social environment that consistently devalues care and those who do it, both in its government policy and cultural norms.

A broad review of the literature on care and carework was presented, including the process and outcomes of carework, as well as an analysis of carework as structured through who gives and who receives care and the various settings in which these exchanges take place. The care lens demonstrates how carework has been structured through gender, race, and class, and that an analysis of carework can reveal privilege and inequality within a society. This kind of devaluation of care has influenced government policy across a wide range of social policy sectors. A summary of Canada's refugee immigration policy was also included in the literature and, together with Canada's family reunification policies, demonstrates a preference for economic immigration above care-based immigration, such as refugee and family reunification immigration policies. These policies construct refugees (especially refugee women who are more likely to be caregivers) and their families as primarily care receivers and ignore the value of their carework, both in its demonstration of agency and resilience and in the benefits for family members in their homes and transnationally in the home countries, as well as the impact of their carework in communities.

For social work and other advocates of social justice and reform, these findings provide a new approach to advocate for immigration reform, particularly in the context of refugee and family reunification policy. These policies do not adequately reflect the realities of providing care, nor do they recognize the value of such carework to society at large. Further, these findings should encourage further development in social work discourse, wherein care responsibilities should not only be discussed as challenges (for example, to employment or integration), but also as adding value and meaning to the migration experience. Lastly, carework for the women interviewed also included activities in community carework that closely align with social work duties in communities; therefore, these findings also provide a new approach for recognizing the value of community social work.

This project is relatively small in scope and relies on qualitative data and theoretical conceptions of care. More in-depth research could be done to explore the connections between the care lens and refugee immigration policy—in particular, an economic analysis of this relationship would provide valuable

insight into argument. It does remain to be determined, however, whether an economic analysis could fully capture what is meant in this study, as represented in the scholarship and by the participants, by the value of carework. While economic valuation of care would be beneficial from a policy reform perspective, it is also important to advocate for recognition of the value of care that goes beyond economic considerations to include a more robust conceptualization of meaning that encapsulates the full impact of care and caring relationships in people's lives.

Including a care lens in the development of policy and settlement practice would assure that the true value of care was accounted for in the refugee determination and acceptance process and services accessed. As conceptually articulated through the ethics of care (Held, 2005; Tronto, 1993), there is strong theoretical evidence that care and caregivers have been unjustly devalued. The narratives presented here provide substance to this theoretical position by demonstrating the complexity and necessity of this work, as well as the inherent value of this work to both care receivers and caregivers. In the context of refugee migration, this is an area of analysis that has been under-explored and more research is need to fully understand the impact of specific immigration policies on refugee caregivers, usually women. The evidence presented here, in agreement with previous research on this topic (CCR, 2004; McMichael & Ahmed, 2003; Rousseau et al., 2001), indicates that family reunification immigration policy, which aims to reunite children with parents and families with their extended families, as well as Canadian refugee immigration policy, in general, do not adequately address the care needs of the families and communities it aims to help. It is argued here that one factor leading to this policy environment has been the social and systematic devaluation of care.

The women interviewed for this project, along with many other refugees who settle in Canada, have been through horrific circumstances, and yet continue to give: in their homes, in their communities, and in communities abroad. Carework like this contributes immensely to the well-being of those it touches and the wider community; therefore, those who do it should not be viewed as non-valuable citizens, but rather have the value of their carework acknowledged and honoured.

Appendix A: Participant Recruitment Letter

McGill

Research Opportunity – Participants Needed!

Study Title: Near and far, with heart and hands: The impact and value of carework in the context of refugee policy and settlement

Dear *XXXXXXXXX*

I am a Master of Social Work student at McGill University researching settlement challenges experienced by refugee women, specifically in relation to their various caregiving roles and responsibilities. I am currently in the process of putting together a qualitative research study that will form the bulk of my thesis. This project has been reviewed and approved by the McGill University Research Ethics Board.

The study will focus on the experiences of women who migrated as refugees to Montreal as they negotiate various caregiving roles. Specifically, it will explore how their experiences of providing care (paid and unpaid) in various settings like home, work, and communities abroad impact their lives in Canada and, in particular, their settlement experience. There is currently a large body of research concerning women who enter Canada through the Live-in Caregiver Program and I want to suggest that other newcomer women may experience the same multi-setting, transnational caregiving responsibilities. This research will examine this supposition further to uncover the unique ways this would impact the settlement of refugee women and their families given their refugee status.

The data collection for this study will consist of in-depth interviews with about 5 women who have entered Canada through a refugee stream of immigration within the last 10 years and are now engaged in both paid and unpaid carework. I am contacting you at *XXXXXXXXX* because of your work with newcomer women in Montreal. I want to inquire as to whether you would permit me to post a flyer in your organization advertising the need for research participants. I have attached a copy of the flyer to this letter for your review.

If you have any further questions or concerns, please feel free to contact me by email at lindsay.larios@mail.mcgill.ca or by phone at 514-236-7358. My faculty supervisor at the McGill School of Social Work, Dr. Jill Hanley, is also available for questions and can be reached at jill.hanley@mcgill.ca. Thank you for your consideration.

Sincerely,

Lindsay Larios

Master of Social Work (pending)
McGill University

Appendix B: Participant Recruitment Flyer

McGill

ARE YOU A WOMAN WHO IMMIGRATED AS A REFUGEE?

ARE CAREGIVING AND CAREWORK A BIG PART OF YOUR LIFE?

RESEARCH PARTICIPANTS NEEDED!

I am a Master of Social Work student at McGill University doing a qualitative research study looking at settlement challenges experienced by refugee women, specifically in relation to their various caregiving roles and responsibilities (both paid and unpaid).

I am looking for women who would be interested in talking with me about how different caregiving roles in their home, at work, and in relation to their communities abroad, impact their lives. All information will be kept confidential and will never be associated with your name.

Who can participate?

Women who have come to Canada through a refugee stream of immigration during the last 10 years, who also engage in both paid carework as employment (in a daycare, homecare, healthcare or other care setting) and unpaid carework in the home (for children, elderly parents, or other adult dependents).

Where will the interviews happen?

Together we will choose a location that is convenient and comfortable for you. Some suggestions could be an office on campus at McGill, the McGill library, your home, or a quiet public place.

How long will the interview take?

It is a one-time interview that will last approximately 2 hours.

Participating in the study will allow you to share your story and have your voice be represented in a body of research that may one day have a positive impact on women with similar experiences to you.

Please contact me, Lindsay Larios, at lindsay.larios@mail.mcgill.ca if you are interested in participating in my project! Questions and concerns may also be addressed to my supervisor, Dr. Jill Hanley of the McGill University School of Social Work at jill.hanley@mcgill.ca.

Appendix C: Participant Consent Form

Participant Consent Form

Study Title: Near and far, with heart and hands: The impact and value of carework in the context of refugee policy and settlement

Principle Investigator:
Lindsay Larios
lindsay.larios@mail.mcgill.ca
School of Social Work, McGill University

Supervisor:
Dr. Jill Hanley
jill.hanley@mcgill.ca
School of Social Work, McGill University

You are being asked to participate in an interview for a research study that will form part of a thesis for the Master of Social Work program at McGill University. Please take your time to review this consent form and discuss any questions you may have with me. If there is anything in the form that you do not understand, please ask me to explain further.

Purpose of Study:
The purpose of this study is to understand how your experiences of providing care (paid or unpaid) in various places like home, work, and communities abroad impact your life in Canada. I hope to learn from your lived experiences to better understand the settlement process for refugee women and to better understand your perceptions of caregiving.

Study Procedure:
This will be a one time only interview lasting 1.5 to 2 hours. I will ask questions to guide the interview and help with the discussion. With your permission, the audio of the interview will be recorded and transcribed by me. This audio information will be used only for the purpose of making a transcript. Only my supervisor and myself will ever have access to this recording. If you do not agree to be recorded, I will take notes throughout the interview instead. Additionally, if you consent, you may provide contact information for the purposes of follow-up and updates on the project.

Potential Risks and Discomforts:
The risks involved in participating in the interview are minimal; however, due to the personal nature of the interview there is some risk of emotional discomfort. Some questions may ask you to reflect on your experiences moving to Canada and your family relationships. You may choose not to answer a question or to stop participating in the interview at any time if you become uncomfortable. If you feel like you cannot manage your emotional discomfort on your own, I will provide you with a list of contact information for appropriate counseling services and resources.

Potential Benefits:
Participating in the study will allow you to share your story and have your voice be represented in a body of research that may one day have a positive impact on women with similar experiences to you.

Confidentiality:
All information gathered in this interview will be done so confidentially and will not be associated with your name at any point. Only my supervisor and myself will ever have access to this information. This research study may be published or presented in an academic forum; however, your name and other identifying information will never be used or revealed. Further, any contact information you may choose to provide for follow-up purposes will be collected separately from your interview and never be directly linked to your interview. Information will only be shared without your permission in cases where a person's safety is threatened or it is required by law.

Voluntary Participation/Withdrawal from the Study:
Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time.

Questions:
You are free to ask any questions that you may have about the research process and your rights as a research participant. If any questions come up during or after the study, feel free to contact me using the above information. For questions about your rights as a research participant, you may also contact the Lynda McNeil at the McGill University Research Ethics Board Office at 514-398-6831 or lynda.mcneil@mcgill.ca.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent:
I have read this consent form and have had the opportunity to discuss this research study with the Principle Investigator/interviewer. The study has been explained to me and my questions have been answered to my satisfaction. I agree to participate in this study. I do not waive any of my rights by signing this consent.

I consent to having the audio of this interview recorded. Yes _____ No _____

I consent to being contacted to hear the results of the study and other follow-up purposes.
Yes _____ No _____

Preferred method of contact: _____

Participant printed name: _____

Participant signature: _____ Date _____

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent.

Principle Investigator Printed Name: _____

Principle Investigator Signature: _____ Date _____

Research Ethics Board Office (REB I,II, III), James Admin. Bldg. Rm 429, Montreal, QC H3A OG4
tel:514-398-6831 fax:514-398-4644 email : lynda.mcneil@mcgill.ca www.mcgill.ca/research/researchers/compliance/human/

Appendix D: Interview Guide

Interview Guide

Personal Information

1. Can you tell me a little bit about how you came to Canada? (e.g. legal status, stream of immigration, how long in Canada)
2. Can you tell me a little bit about your family here in Canada with you? (e.g. spouse, children, extended family)
3. Can you tell me about the kind of employment you have? (e.g. job title, full--time/part--time, how long you've worked there)
4. Can you tell me what an average day is like for you?

Home (OR, what kind of unpaid carework do you do/have you done?)

5. Who do you care for in your home?
6. What kinds of tasks do you do to care for your family?
7. How much time would you say you spend doing these things per day?
8. How do you feel about this work? (Do you enjoy it? Does it keep you from doing other things? Etc.)
    a. What things about it make you feel good?
    b. What things are challenging about it?
9. Are there things about this work that you would like to change?
10. Does anyone help you with this work?
11. Are there tricks or strategies you have developed to help with this work or make it more manageable?
12. Are there any services you use that help you in your role as a caregiver in your home?
13. Is there any other kind of unpaid carework you do outside your home (e.g. in the community) that you want to speak about?

Work (OR, what kind of paid carework do you do/have you done?)

14. What kind of care--related tasks do you do in your job?
15. Is this different from the kind of job you had in your home community abroad?
16. What kinds of things influenced you to take this job (or other carework jobs)?
17. How do you feel about this work?
    a. What things about it make you feel good?
    b. What things are challenging about it? (e.g. wage, conditions, hours?)

18. Are there things about this work that you would like to change?
19. Often carework can be very intimate and you can form personal relationships with those for whom you are caring, even when you paid for it – can you tell me about this experience?
20. How do these relationships influences how you feel about your work, specifically the physical tasks you have to perform?
    a. Is there any sense in which the relationships make the carework more rewarding?
    b. Is there a sense in which the relationships make the carework more challenging?

Abroad

21. Do you still have family abroad that you are in contact with?
22. If so, would you describe these as caring relationships?
23. Were there caring roles you had to give up when you left your home country?
    a. Did someone else fill this caring role when you left?
24. What sorts of things do you do to take care of family or other loved ones abroad now? (e.g. send money, phone calls, sponsorship plans?)
25. How do you feel about this experience of caring?
    a. What things are the most gratifying?
    b. What things are the most challenging?

Transnational perspectives

26. In what ways was your role as a caregiver different in your home community abroad compared to your role as a caregiver here in Canada now?
27. What differences do you notice about caregiving here compared to your home community?
28. How does this influence how you care for your family or those around you in your job now?

Settlement

29. How has your immigration to Canada affected your experience as a caregiver?
30. Is there any sense in which your caregiving obligations (in any of the settings we've talked about) have been a barrier to your settlement into Canadian life? (e.g. education, employment?)
31. Is there any sense in which being a care provider has had a positive effect on your experience settling into Canadian life?

Conclusions

32. Thank you for talking with me today. Those are all the questions I have for you. Are there any further comments you'd like to make before we end?

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