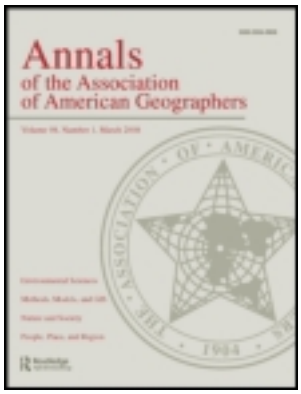

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Migrant Workers in Home Care: Routes, Responsibilities, and Respect

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We consider the increasingly common provision of home-based health care by migrant care workers. In particular, we explore the racial division of paid reproductive care and ideas about embodied work to show that although (im)migrants tend to fall to the bottom of the hierarchy of care work, the reasons are multifaceted and complex. We draw on interview data from a larger study of long-term home care in Ontario to explore the lived experience of care work by migrant workers, emphasizing their social agency. We organize our discussion around the themes of routes, responsibilities, and respect and emphasize the embodied and power-inflected care work relation. Through these themes we explore the different routes the migrants took into care work—how they found their jobs and what role those jobs play in their lives. Then we address the responsibilities of different home care jobs and the relational dynamic of how job responsibilities are actually practiced. Finally, the theme of respect examines how the workers try to treat their clients with dignity but sometimes the work relation is marked by racism and friction over what counts as "good" care. We show that care work is constructed and experienced through a complex interweaving of embodiment, labor market inequalities, and the province's regulatory mechanisms of care provision. *Key Words: care, embodiment, migrants, racialization, work.*

我们认为，由移民保健工作者提供的，以家庭为基础的医疗保健，已越来越普遍。特别是，我们通过探索带薪生育保健的种族分化和其所体现的工作思路来表明，虽然移民倾向于从事底层护理工作，其原因是多方面的和复杂的。我们借鉴位于安大略省所进行的一个长期家庭护理的大型研究采访数据，探讨移民工人的护理工作的生活经验，强调他们的社会机构。我们围绕路线，责任和尊重的主题，并强调所体现的和受权力所驱的护理工作关系。通过这些主题，我们探讨移民所采取的不同的加入护理工作行业的方法，即他们怎样找到的工作，和这些工作在他们的生活中发挥了什么作用。然后，我们探讨不同家庭护理工作的责任，以及这些岗位职责的关系动态是如何实行的。最后针对尊重的主题，探讨虽然这些工人如何尝试有尊严地对待他们的客户，但是有时工作关系被打上种族主义的标志，并在什么是"好"的护理标准上存在分歧。我们的研究表明，护理工作是通过错综复杂的原因交织，劳动力市场的不平等，和该省护理服务的监管机制来构建和进行的。*关键词：护理，体现，移民，种族化，工作。*

En este estudio consideramos la provisión cada vez más común de servicios de salud a domicilio por trabajadores migrantes de salud. En particular, exploramos la división por raza de atención reproductiva paga e ideas acerca del trabajo personificado, para mostrar que aunque los inmigrantes quedan ubicados en el fondo de la jerarquía del trabajo de atención, las razones son multifacéticas y complejas. Nos basamos en entrevistas realizadas en un estudio mayor de atención de largo plazo en hogares de Ontario, para explorar la experiencia vivida en el trabajo de atención por trabajadores migrantes, haciendo énfasis en su agencia social. Nuestra discusión la organizamos alrededor de los temas de rutas, responsabilidades y respeto, y enfatizamos la relación del trabajo de atención personificada y ajena a intereses de poder. A través de estos temas exploramos las diferentes rutas que siguieron los migrantes para llegar a este tipo de trabajo—cómo consiguieron este empleo y qué papel juega en sus vidas este trabajo. Luego abocamos las responsabilidades de los diferentes empleos de atención domiciliaria y la dinámica relacional sobre cómo se practican realmente las responsabilidades del trabajo. Por último, el tema del respeto examina la manera como los trabajadores intentan tratar a sus clientes con dignidad, aunque algunas veces la relación de trabajo esté marcada por racismo y fricción sobre qué es lo que cuenta como "buena" atención. Mostramos que el trabajo de atención se construye y experimenta a través de un complejo entretejido de personificación, inequidades del mercado laboral y los mecanismos reguladores de la provincia sobre provisión de cuidados de la salud. *Palabras clave: atención de la salud, personificación, migrantes, racialización, trabajo.*

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The ongoing restructuring of health care systems greatly impacts the working conditions and experience of health care workers. In Canada a growing proportion of those health care workers are foreign-born, as is the case in the United Kingdom and the United States. Much attention centers on the transnational migration of doctors and nurses or on migrants employed in the low-paid, nonprofessionalized health care occupations in institutionalized workplaces like hospitals and nursing homes. There is relatively little work, however, on the growing proportion of migrants working in community-based home care. In this article we focus on this particular and increasingly common group of health care workers. We bring together threads from existing literature on theorizing social reproduction, gendered and racialized inequalities in paid employment, and the marginalization of care in capitalist economies. Sifting through that scholarship in light of our empirical findings, we identified three overarching themes: routes (immigration process, job search, and credentials), responsibilities (tasks, rules, and family), and respect (being valued, discrimination, and work dynamics). We focus on the lived experience of home care workers and address these themes in a fashion that emphasizes their social agency. Too often (im)migrant care workers are positioned as passive participants, trapped into accepting lower wages and undesirable jobs. We advocate a more complex interpretation whereby numerous processes and practices come together to produce an evolving labor market that seems to slot women into particular jobs but where women also have initiative and make "rational" choices.

We use Zimmerman, Litt, and Bose's (2006, 3–4) definition of care work as "the multifaceted labor that produces the daily living conditions that make basic human health and well-being possible." This particular definition appeals precisely because it is multifaceted. It includes the most common understanding of care work—the care of children, the elderly, and people with illnesses and disabilities. These equate to the relational, responsive, face-to-face aspects of care work noted in the care ethics literature that emphasizes the emotional and power-inflected dynamic of interdependent care relations (Kittay 1999; Tronto 2005; Bondi 2008). Zimmerman, Litt, and Bose's definition, however, also includes the more instrumental, less relational activities of housekeeping and domestic tasks such as cleaning floors, grocery shopping, and cooking.

We draw on the literature about the social organization of jobs in care work. Glenn (1992) was among the first to identify a "racial division of paid reproductive labor"—a hierarchy where white women tend to hold face-to-face supervisory and professional positions (e.g., nurses and social workers), and women of color do the "heavy, dirty, 'back-room' chores of food preparation and cooking, cleaning, changing bed pans and the like" (20). More recently, Glenn's racial division of paid reproductive labor has been taken global by scholars placing it in the context of the transnational migration of care workers. For example, Parreñas (2001) and Hondagneu-Sotelo (2007) expanded Glenn's framework to argue that low-wage migrant women of color are found at the bottom of the racialized hierarchy of paid reproductive labor and the increase in migrant domestic workers in the global north equates to an international transfer of caregiving from the global south. In geography, too, this transnational migration of domestic workers is an important research topic. Much of that work has looked at employer–employee relations in the live-in caregiver situation, where the empirical focus is on paid care in a single home (e.g., Pratt 2004; Cox 2006). We know less about the experience of care workers hired by agencies working shifts in several different homes (but see Meintel, Fortin, and Cognet 2006). These workers receive instructions from their agencies and then go into people's homes, where the actual care provided is also the result of negotiations with the client and depends on the materiality of each home.

The racialized migrant division of paid reproductive labor underscores the physicality of the actual bodies doing care work. In the literature on embodiment, the concept of "body work" is used to describe the close, intimate, often messy work carried out on other people's bodies (Twigg 2000; McDowell 2009; England and Dyck 2011). Curiously, the corporeal aspect of paid work is often overlooked, even though work is embodied and the corporeality of difference is played out in the divisions of labor. Some scholars address the embodied practices of low-wage workers in other labor market sectors, suggesting that work practices literally embody global capital labor processes: cleaning hotel rooms, cooking and serving restaurant meals, and cleaning the offices of global elites (e.g., Aguiar and Herod 2006). In the case of home care, there is a dual embodiment because not only is the worker's body the direct instrument of care, but also his or her labor focuses on other people's bodily functions, such as toileting and catheter management. Moreover, the particular worksites of labor processes also play a constitutive part in the embodiment of political economy. In our study these multiple embodiments of care work occur in the putatively private homes of care recipients, and as our

focus is on international migrants, some falling to the bottom of the racialized division of paid reproductive labor, global processes are also brought into the homes of care recipients.

The Study and Data

The context of our research is the neoliberalized restructuring of the Canadian public health care system. Health care provision is a provincial responsibility and in Ontario neoliberalized health care means shorter hospital stays and patients moving from hospitals into community care sooner than in the past. It is also cheaper for older people to be attended to via publicly funded home care rather than in hospitals or nursing homes. Thus, a large proportion of home care services are provided to people who have chronic illnesses, physical disabilities, or age-related frailties. Ontario now provides home care through a process of managed competition. The province is divided into regional Community Care Access Centers (CCACs), which assess individuals' care needs and determine their level of service, and nonprofit and for-profit agencies compete for contracts to deliver services within a particular CCAC. The managed competition process introduced stricter eligibility requirements and reductions in the number and length of home visits by home care workers (see England et al. 2007).

Our analysis is based on an ethnographic, multidisciplinary study of home care in Ontario. Data were collected from seventeen cases recruited from across the province via our partnering CCACs. Each case included interviews with the care recipient, the paid care workers, and (if relevant) the family caregiver. All care recipients were receiving services from agencies that won contracts from their CCAC, and the paid care workers were employed by those agencies.[1] In this article we restrict our analysis to the eight cases in which one of the paid care workers is an immigrant. All were women who migrated to Canada as adults. Three were born in Jamaica, and one each came from Chile, Germany, Eritrea, Kenya, and Morocco.[2] Ivy (Jamaican) had lived in Canada the longest (twenty-six years) and Irma (Kenyan) the least (six years). We do not intend this to be a representative sample; rather, they allow us to trace general processes and make theoretical points about migrant home care workers in relation to the broad categories of routes, responsibilities, and respect. In some instances the migrants' narratives echo those of Canadian-born workers, such as seeking dignity through their work. In other instances, the immigration process makes a significant difference, such as influencing why they went into and stay in home care.

Routes

The theme of routes came up in various ways in the care workers' narratives. Obviously, as immigrants, all of the women had taken international routes to wind up in home care jobs; some arrived in Canada as sponsored family members, whereas others came as refugees. Some came directly to Canada from their county of birth, and others came via other countries. Jocie, a registered nurse (RN), elected to come to Canada from Morocco via the United Kingdom; Rahma (attendant) fled Eritrea and lived in Kenya for a decade before she, her husband, and their younger children moved to Canada. Jocie's route most closely fits within the frame of the transnational migration of skilled workers (Kofman and Raghuram 2006). She went to England to train as a nurse. As a French speaker, she then immigrated first to Québec and later to Ontario.

There were other routes taken into care work. Most of the personal support workers (PSWs) and attendants in the larger study (but not the RNs) found their way into home care work through personal contacts. This echoes Hanson and Pratt's (1995) finding that women in female-dominated work tend to find jobs through other women in their social networks, rather than through formal channels. For example, Brenda (attendant, Jamaica) got her first job twelve years earlier when "a friend told me about [the agency]; I called and started working two hours a day. At first I didn't think it would last [laughs]." Of course, this is one way that occupational segregation is reproduced, because information comes from "strong ties" (i.e., friends, family, and neighbors), as in Brenda's case. As a job search technique, however, informal methods provide an insider's view about what to expect on the job and information about the norms around tasks, pay, vacation time, and so on. From the viewpoint of the home care agencies, word-of-mouth recruiting is a cheap and quick way to fill PSW and attendant positions and might mean less turnover than among those hired through formal means. Perhaps, then, it is not surprising that Brenda's employer interviewed her within twenty-four hours (others talked of similarly fast-moving hiring processes).

The educational achievements of the migrant women are highly varied and cannot be conveniently mapped onto the figure of the "poorly educated immigrant woman" channeled into paid care jobs as a

last resort. Valentina (attendant, Chile) held a BA from Chile; Brenda (attendant, Jamaica) had some postsecondary education; and Rahma, an Eritrean refugee, had less than a high school education (most of the Canadian-born home care workers had some postsecondary education; two had BAs). Valentina exemplifies the evident frustrations of immigrants who find that they are unable to translate their professional skills into the Canadian labor market. "Well, I am immigrant," she said. "In Canada I never worked [as a librarian] because in my country the degree is not a master's, it's a BA. Here they're looking for a master's degree for a librarian."

Certainly, a growing literature points to the negative labor market and poverty implications for recent immigrants, like Valentina, whose credentials and work experience from their countries of birth are not recognized (Preston, Lo, and Wang 2003; Creese, Dyck, and McLaren 2008). Irma had similar difficulties to Valentina but experienced a different outcome. When she first arrived in Canada, Irma had already trained as a nurse in Kenya and was keen to find a nursing job, but she had to get licensed before she could be an RN. In the meantime, Irma remarked, "All I could do was work in home care, and I worked too in a nursing home as an aide. I could not do any more until I qualified as an RN." When the required documentation of her credentials was finally retrieved from Kenya there were still issues with her qualifying in Ontario. In the end, the wife of one of her care recipients took up the cause and, Irma said, the wife "went to the College and complained. I was afraid; I did not want to make trouble. But after she spoke with them I was allowed to write." Finally, five years after her arrival, Irma was able to do training "to make sure I know the procedures here, to learn the proper terminologies." She found the training easy, "similar to back home in Kenya," and had recently passed the exam. Yet, she said:

> Apart from the high technology here, I don't feel it is very different. You still must know how to look after the patient's comfort. The physical care is still the same. It doesn't change if you are in a different country. It doesn't mean that the patient has different symptoms. It's only the high technology that is new.

When asked how they got attracted into home care, the immigrant women offered different explanations than the Canadian-born women. Home care work was more readily available to them than other jobs because agencies were less concerned about their lack of work experience in Canada, gaps in their paid-work history, and, for the non-English speakers, their limited language skills. Home care work could usually be fitted around their family responsibilities; for example, Jocie (RN, Morocco) worked part time as her children were young. Others talked of going into care work to bolster their family's standard of living or in response to their husband's unemployment or job insecurity. Rahma (attendant, Eritrea) spoke often of her family's financial struggles and repeatedly said she was happy to be working, even though she knew she was not well paid and sometimes had to work six days a week: "I'm helping my husband and helping my family because things are expensive for us." Like many of the women, Rahma was also sending remittances to support her extended family. Thus for many, despite its shortcomings, care work is desirable work; it offers some job security and provides workers' families with a critical means of economic survival. Even poorly paid care work is understood by many of those in it as offering important opportunities for women from a range of backgrounds to contribute to their family's income (Giles and Preston 1996).

Responsibilities

In Ontario, 30 percent of the 2006 employed labor force was made up of immigrants, whereas immigrants make up 28 percent of RNs, 22 percent of registered practical nurses (RPNs), and 38 percent of PSWs and attendants. Although only subsets of these are employed in the home care sector, the census statistics give a flavor of the migrant division of health care work. Across all seventeen cases in our home care study, twenty-nine paid care workers were interviewed, of whom twenty-one were Canadian-born. Of those, nine were RNs and eight were PSWs or attendants (and two others were RPNs and one was a physiotherapist). On the other hand, six of the eight migrant workers were PSWs or attendants, and the two others were RNs, Jocie (Morocco) and Leah (Jamaica). This admittedly small group of migrant care workers does reflect the racialized divisions of paid reproductive labor described in the literature (see Meintel, Fortin, and Cognet [2006] for an example from another Canadian province). On closer analysis, however, we find more complexity. For example, Jocie is at the higher end of the care hierarchy. She is a "high-tech" nurse, with advanced training in intravenous technology management. These highly sought-after skills make her, as she puts it, "part of a specialized team" responsible for numerous clients across an extensive territory.

Increasingly, nurses (in all work settings) are "high tech, low touch," dealing with assessments and the more

technical aspects of care. Reflecting Twigg's (2000) observations about hierarchies in nursing, the work of RNs is marked by distance from the direct, intimate care of bodies. The more labor-intensive, high-touch body work is usually the responsibility of PSWs or attendants. Their responsibilities include the personal care of their clients' bodies, often carried out in the most intimate spaces of home (bedrooms and bathrooms). Their jobs transgress the bodily and domestic boundaries of normative social interactions. The care workers' discussion of intimate body work (bathing, toileting, catheters) points up crucial elements involved in the actual practice of home care work, often demonstrating the skill involved in this devalued, supposedly unskilled work. Brenda (attendant, Jamaica) describes how she bathes one care recipient:

> So we talk and talk until we reach upstairs and she's in bathtub. You have to talk with them because they don't really want to have a bath. And by the time the conversation is over she's getting lathered with soap, and says, "Oh you tricked me." All the time she doesn't realize what's happening yet. She's a darling; I like that one, even though sometimes she don't want to have the bath.

Specific job responsibilities are laid out by provincial health care policy guidelines that then inform the formation of home care relations and how care is actually put into practice in the clients' homes (England and Dyck 2011). Care agency constraints on time allocated to tasks and the legal demarcation of job category boundaries further impact home care work practices. For instance, Irma (Kenya) is employed part time as an attendant for a home care agency, but she also holds a second, more lucrative job working night shifts as an RN in a hospital. Irma's experience demonstrates how provincial policy directives and agency regulations reinforce occupational divisions of care work. When asked if there were rules about what tasks she was allowed to perform, she responded:

> I am working here as a homemaker, but if there is a dressing [needed] I am not allowed to do that. They have to get a nurse. Even though I am [qualified] to do it, it has to be done by a nurse. [But] I do that in the hospital, because there I work as a registered nurse.

Irma's embodied labor involves her crossing the divisions of paid care work on a daily basis and shows how specific care sites (home or hospital) co-constitute the corporeal practices of care work.

The relational dynamic of care work involves a careful weaving together of negotiating boundaries, embodiment, and the care worker's own sense of appropriate care (what Datta et al. [2010] described as a "migrant ethic of care" wherein their life experience and cultural values shape their perceptions of what constitutes good care). For example, care recipients seek to maintain their modesty and dignity and at the same time the care workers negotiate "the rules" of their employer and shape their own work practices to help their clients. We did find that the Canadian-born care workers are more likely to bend the rules further or push back against the agencies in ways that risked their jobs. Generally the immigrants were more circumspect. For example, Rahma (attendant, Eritrea) said, "I tell her now it's more than two hours but I'll finish [the laundry], and tomorrow when I come, I cut the time from her." Rahma was the most concerned about calling the office for permission to do certain things. For her, keeping her job was critical for her family's finances, so she was not prepared to jeopardize that. She also pointed out, however, that she used the rules as a strategy for maintaining clear boundaries with clients: "I say 'I don't have permission, I can't do this,' " when asked to do tasks beyond her job description or to stay beyond the allocated time.

Respect

Respect is central to an individual's feeling of self-worth and self-esteem and is a fundamental part of the dynamics of paid work relations. Obviously the amount of respect experienced by care workers (and the care recipient) is highly variable and nuanced, dependent on the specificity of the relationship, along with the comfort level about negotiating material care practices in a particular situation. As Bondi (2008) showed, the care work relationship is inflected by both power and affect or emotion on both sides of the relationship. For example, Irma (attendant, Kenya) explained that William is ashamed of being naked before strangers, yet his daily home care is about bathing and dressing. His modesty, she explains, is "his proud character" and his embarrassment about his loss of bodily control: "That is why he hates a different provider coming to him every day. That is why it must be the same person." And that "same person" is Irma. Although she is now an RN, she continues as William's attendant on a part-time basis.

Irma's particular relationship can be seen as an example of the "international transfer of caregiving" that Parreñas (2001) described, although in this case it is transferred to an elderly, incontinent man with limited motor skills rather than a child. Irma describes her

relationship with William and his wife as being like family. She does not use this label unreflexively, as she said that being part of a family means you observe behavior over a long period of time and come to understand people very intimately: "It is not all sweetness, though you care about them very much." Respect, individuality, being mindful of their client's privacy (within their home, but also at the scale of the body), and treating them with dignity were common threads in the care workers' interviews.

Another aspect of respect is about language skills contributing to difficult working conditions. We found this thread in the interviews less often than we expected. Language skills were not raised in any substantive way by Alexa (attendant, Germany) or Jocie (RN, French-speaking Moroccan), nor by their care recipients. It came up in passing in Rahma's case (attendant, Eritrea), who speaks broken English and is working to develop her language skills. The issue of accented English came up in the case of the native English-speaking women, however. In their study of African immigrants in Vancouver, Creese and Kambere (2003) found that despite coming from English-speaking former British colonies where the education system is also British based, their "accent" and race mark them as immigrants. Ivy, originally from Jamaica, migrated to Canada twenty-six years earlier. Ivy's client Bernice remarked that "I can't understand her half the time—what she's talking about? She's been here for twenty-five years . . . you know how thick her accent is." Bernice linked this directly to what she described as Ivy's laziness and said "I can't take any more of (Ivy's) stupidity." Bernice also devalues Ivy's care work, for example, complaining that her cleaning "is slipshod. . . . Like today I asked her to clean the bathroom; she stands in the hall and shoots Lysol through the door and that's the bathroom clean." Bernice's remarks were the clearest example from our data of the intermingling of anti-immigrant and racist discourses: "Common-sense discourses [that] construct people of color as immigrants and immigrants as people of color" (Creese and Kambere 2003, 566). Bernice pulls on a racist script to describe her changing care provision situation, when it is likely that Ivy's allocated time for Bernice has been cut because of home care restructuring. This also echoes experiences of racism and discrimination reported by home care workers in Québec (Meintel, Fortin, and Cognet 2006), and migrant nurses in the United States, suggesting that "foreign" care workers are scapegoated when the effects of economic and labor force restructuring reverberate on a global scale (Ball 2004).

Changes in publicly funded home care also help explain the reactions of another care recipient. Hannah said that until Valentina (attendant, Chile):

> Every single caregiver [the agency] sent was from the Caribbean. They were sending a different person every single day, a different one. It was SO hard for me. The majority of them were lazy. They came in with these huge bags, God knows what they took.

In addition to accusations of "laziness," Hannah raises another theme that emerged in several cases (including those with Canadian-born workers): thinly veiled accusations of theft. Again troubling in what this reveals about racism and lack of respect for care workers, these unpleasant remarks could also be understood as the vulnerability arising from the lack of continuity of care and the difficulty of "opening your home to strangers" expressed by several care recipients.

Hannah was increasingly fearful that Valentina would resign from her job as an attendant. In her interview, Valentina seemed to be struggling with her own identity and self-respect: "I'm a librarian, not a housekeeper," she said at one point in her interview. In addition, after several months of helping Hannah bathe, cleaning her home, and preparing meals (Valentina complained of peeling lots of potatoes and carrots), she believed that her own health was beginning to suffer (wrist pain). Hannah said Valentina had discussed this with her but then remarked that Valentina was "too cheap to buy some carpal tunnel splints." The relational production of respect (or perhaps demise of it!) in this particular situation flags a second set of vulnerabilities. Narratives of vulnerable bodies abound but usually only in reference to care recipients. In our more relational understanding of care work, there is a dual vulnerability of both the paid care workers' and the care recipients' bodies—a trusted caregiver starts suffering from work-related health problems (e.g., carpal tunnel syndrome) that impacts her ability to work with a client, and this might mean that the "vulnerable" client faces problems with continuity of care, which in turn impacts the client's health. In a context where home care reform means cost cutting and rationing care, recipients feel vulnerable to having their service cut. Care workers, on the other hand, are concerned about their job security and new work practices that leave them questioning how (or if) they can continue providing quality care that allows them to maintain their own health, fits within their ethic of care, and still adheres to rules about what is allowed and paid for by the system.

Conclusion

Although these data are from a Canadian study, with particular health care policies and agency directives affecting the routes taken by migrant workers, their job responsibilities, and their sense of respect, our article reflects and informs other scholarship on migrant workers in multicultural settings in the global north. The globalization of care work links together the transnational flows of women and a range of care jobs that are frequently poorly paid and undervalued. There is also recognition of the sometimes demanding and demeaning conditions under which paid care workers perform their work. Certainly our study suggests that there is a racialized migrant division of paid reproductive labor in Ontario, but we have deliberately highlighted the social agency and "rational" choices of migrant care workers in our discussion of the routes, responsibilities, and respect associated with home care jobs. Although the association of paid care work as "women's work" endures, we show that it is a viable, even attractive, option for women with limited avenues for economic survival.

We show that the social organization of labor serving capital interests has effects at the scale of the body, including the bodies of those providing care. That the care workers in our study are immigrants further complicates the work relation and actual practices of care work. Moreover, our embodied approach draws on racialized divisions of labor to underscore the significance of an intersectional approach that embeds care work within power hierarchies of gender, race, and class. As racialized workers, the women in this study experience their access to care work and the day-to-day experiences with care recipients in a context inflected by their global migration, intertwined with labor market inequalities along with provincial policy directives and agency rules. Thus, they might have to endure racism in particular care work situations, and many apply a "migrant ethic of care" to their work rooted in their own life experiences and the skills they bring to the workplace. In these instances, the global enters the intimate spaces of Canadian homes via migrant care workers, which can transform the very meanings and practices of care work. Most obviously the racialized occupational hierarchy within the care workforce is evident in the overrepresentation of migrant women in the more "dirty work" of care work, compared with their Canadian-born counterparts. Despite this occupational clustering, we argue that even for those at more marginalized intersections within multiple hierarchies of power there is still social agency, resistance, and choice.

Notes

1. The participants' names are pseudonyms. The qualitative research was funded by the Social Sciences and Humanities Research Council of Canada. The research team was led by principal investigator Patricia McKeever and included co-investigators J. Angus, M. Chipman, A. Dolan, I. Dyck, J. Eakin, K. England, D. Gastaldo, and B. Poland and research coordinator K. Osterlund. We thank the clients, their families, and the care workers for their time, energy, and enthusiasm in participating in this research.
2. The Canadian-born nurses who volunteered their ethnic background were of northern European (primarily British) origin or in one case, Ukrainian descent.

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